INFLUENCE OF LONELINESS AND LEISURE TIME ACTIVITIES ON GENERAL HEALTH AMONG ELDERLY PEOPLE

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Certificate

Certified that the work entitled **"Influence of loneliness and leisure time activities on general health among elderly people"** has been completed under my supervision by **Ms. Samreen Naseem**. The work is original and has been independently pursued by the candidate. It reports some interesting findings and contributes to the existing knowledge of the subject.

I permit the candidate to submit the work for the award of the degree of Master of Philosophy in Psychology of the Aligarh Muslim University, Aligarh.

(Dr. Asiya Aijaz)
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Dedicated

To

My Loving Parents

ABSTRACT

Influence of loneliness and leisure time activities on general health among elderly people.

In earlier days people did not aware about their health conditions as their was lack of education but in today's scenario, each and every individual is conscious about health. They want to enjoy their healthy life. The present study, was, therefore, undertaken to study the influence of loneliness and leisure time activities on general health. The main objectives of the study were (1) to investigate the impact of loneliness on general health, (2) to investigate the impact of leisure time activities on general health, (3) to find out whether or not interactional effect exist between two independent variables on dependent variable i.e., general health. To achieve these objectives a 2 x 2 factorial design in which one personality variable (loneliness) and one social variable (leisure time activities), each varying in two ways, was used in the present study. The two values of personality variable, i.e., loneliness were (a) high lonely and (b) low lonely. The two values of social variable, i.e., leisure time activities were (a) greater number of leisure activities and (b) less number of leisure activities. Thus, there were 4 groups of subjects, namely:

1. High Lonely –High in Leisure Time Activities
2. High Lonely – Low in Leisure Time Activities
3. Low Lonely – High in Leisure Time Activities
4. Low Lonely – Low in Leisure Time Activities

In order to form above mentioned four groups of subjects, Loneliness scale (Russell, Paplau & Cutrona, 1980) and Leisure Time Activities check list (Van Willigen & Chadha, 1989) was administered on 410 subjects. The subjects whose score on Loneliness scale fell on or below 1st quartile (Q_1) were considered as Low Lonely while the subjects whose score on Loneliness scale fell on or above 3rd quartile (Q_3) were considered as High lonely. We got two groups of subjects, i.e., High Lonely & Low lonely groups. The subjects whose score on Leisure Time Activities fell on or below 1st quartile (Q_1) were considered as low in leisure time activities, while the subjects whose score on Leisure time activities fell on or above 3rd quartile (Q_3) were considered as high in leisure time activities. Hence four groups

of subjects were formed and on these groups the General Health Questionnaire-28 (GHQ-28), developed by Goldberg & Williams (1988), was administered to asses the general health of the subject. As soon as the subjects finished their task, the test was collected from them and scoring was done. The data thus, obtained were tabulated group-wise and were statistically analyzed using analysis of variance to draw necessary inferences.

The findings of the present research were (a) subjects experiencing high lonely and low lonely differ with respect to general health, (b) high in leisure time activities and low in leisure time activities had differential effect on general health and (c) interactional effect was found statistically insignificant. The findings were discussed in the light of previous studies and other potential explanations were offered.

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Chapter I

Introduction

INTRODUCTION

Health is a common theme in most cultures. Infact, all communities have their concepts of health as part of their culture. In some cultures health and harmony are considered equivalent; harmony being defined as "being at peace with self, the community, god and cosmos". The ancient Greeks and Indians shared this concept and attributed disease to disturbance in bodily equilibrium of what they called "humors".

Historically, the term 'health' is derived from an old Anglo-Saxon word 'haelth', meaning the conditions of being safe and sound, or whole. However this historical definition was lost because of the common belief that health was in essence freedom from disease.

Over the past 55 years, India's health scenario has undergone considerable changes. Life expectancy has increased from 32 to 62 years, birth rate reduced from 41 to 26 and death rate has fallen from 27 to 9 per thousand. Yet a fact remains that India's health sector is currently facing numerous challenges. The rapidly growing population is the greatest challenge before us. The risk of the fatal disease has increased to a greater extent. The factors are bound to affect the quality of life (Discover India, 2000)

Fortunately, India has a very deep rooted tradition of good health practices since ancient times. People have high level of health consciousness and knowledge of treatment of diseases.

Smith (1990) observed "in the past, good health meant the absence of disease". Today, the definition of health is high level wellness that goes beyond the absence of disease toward one's maximum health potential which includes mind, body and spirit. High level wellness is the integration of five health components which are: emotional, physical, social, spiritual and mental. Davis, Penington, and Stone (1989) suggest that combined use of these elements can lead to high level wellness.

It is generally observed that an individual with a positive attitude towards his health is also more careful and concerned about his health, affecting his attitude

towards life i.e. he may perceive the word as more purposeful as compared to the one who is careless about his health.

Fontana, Marcus, Dowds and Huges (1980) speak of psychological health not merely as the absence of psychological impairment, but rather as separate state making its own contribution to a person's overall psychological wellbeing.

Health is undoubtedly the greatest bounty of Nature to an individual. To the person who has lost his health, it is most priceless possession of all. As Sir William Temple wrote: "Health is the soul that animates all the enjoyments of life, which fade and are tasteless without it". Franklin P.Adams stated health is the thing that makes you feel that now is the best time of the year. To the person who has lost his money, health is one hope. To quote an old Arabian Proverb: "He who has health has hope, and he who has hope has everything". Disraeli once pointed out the significance of health to the state and nation in these words: "The public health is the foundation upon which reposes the happiness of the people and the strength of the nation".

CHANGING CONCEPTS AMONG PROFESSIONALS

Not only among the general public, confusion about the concept of health prevails today even among professionals. Health has been viewed by different scientists (e.g. biomedical scientists, sociologists, health administrators, ecologists, economists, etc) from different viewpoint giving rise to different concepts. These may be briefly described as under:-

(a) Biomedical Concept

The Biomedical scientists have traditionally defined health as "absence of disease" and disease as deviation from a biomedical norm. This biomedical concept, based on the germ theory of disease, which dominated medical thought at the tirn of the 20^{th} century, looked upon the human body as a machine, disease as the consequence of the breakdown of the machine, and one of the doctor's task as to repair the machine. Despite its spectacular popularity and acceptance, the biomedical model was found inadequate to solve some of the major health problems of mankind such as, the population problem. Problem of malnutrition, chronic diseases, accidents, mental illness, drug abuse, insecticide and bacterial resistance, etc.

(b) Ecological Concept

Limitations of the biomedical concept gave rise to other concepts, one of which that has drawn particular attention is the ecological concept. The ecologists viewed health as a harmonious equilibrium between man and his environment, and disease as a maladjustment of the human organism to the environment.

(c) Bio-social and Bio-cultural Concepts

Development in social sciences revealed that disease is both a biological and social phenomenon. The social scientists, therefore asserted that not only biological factors, but also social, cultural, economic, and psychological factors should be taken in to account in defining health and disease.

(d) Holistic view of Health

The Holistic view is a synthesis of all the above concepts. According to this concept, health is viewed as a multi-dimensional process involving the well-being of the whole person in the context of his environment. This view corresponds to the view held by the ancients that health implies a sound mind, in a sound environment. The holistic approach presupposes that all sections of the society have an impact on health.

"Health" is one of those terms which most people find it difficult to define although they are confident of its meaning. Therefore, many definitions of health have been offered from time to time, including the following:

Webster said that "the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain".

"Soundness of body or mind; that condition in which its function are duly and efficiently discharged" (Oxford English dictionary)

"a condition or quality of the human organism expressing the adequate functioning of the organism in given conditions, genetic and environment".

The widely accepted definition of health is that given by the World Health Organization (1948) in the preamble to its constitution, which is as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The WHO definition goes beyond the mere absence of disease. It envisages three dimensions or components of health ___ Physical, mental, and social all closely related. A fourth dimension has also been suggested, namely, spiritual health.

The definition of the WHO is still extensively quoted, although the organization has developed its view considerably since that time. This historic definition has also been heavily criticized, mainly on two grounds. One is that it is totally unrealistic and idealistic (how often does anyone truly feel in a state of 'complete physical, mental, and social wellbeing?) The other criticism is that it implies a static position, whereas life and living are anything but static. The idea that health means having ability to adapt continually to constantly changing demands, expectations and stimuli can be seen to be preferable.

DIMENSIONS OF HEALTH

The above discussion and an analysis of the foregoing two definitions inevitably lead one to conclusion that the concept of health is multidimensional. These dimensions are as follows:

(a) Physical Dimension

This is Perhaps the most obvious dimension of health and is concerned with the mechanistic functioning of the body. It conceptualizes health biologically as a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body. The signs of physical health in an individual are: "a good complexion, a clean skin, bright eyes, lustrous hair with a body well clothed with firm flesh, a sweet breath, a good appetite, sound sleep, regular activity of bowels and bladder and smooth, easy, coordinated bodily movements. All the organs of the body are of unexceptional size and function normally; all the special senses are intact.

Evaluation of Physical Health:

According to modern medicine various tools and techniques are used in various combinations for the assessment of physical health. These are as follows:-

- Self assessment of overall health
- Inquiry into symptoms of ill health and risk factors

- inquiry into medications
- inquiry into levels of activity (e.g., number of days of restricted activity within a specified time, degree of fitness)
- inquiry into the use of medical services (e.g., the number of visits to a physician number of hospitalizations) in the recent past
- standardized questionnaires for cardiovascular diseases
- standard questionnaires for respiratory diseases clinical examinations
- nutrition and dietary assessment
- biochemical and laboratory investigations

At the community level, the state of health may be assessed by such indicators as death rate, infant mortality rate and expectation of life. Ideally, each piece of information should be individually useful and when combined should permit a more complete health profile of individuals and communities.

(b) Mental Dimension

Mental health is not mere absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose.

Mental and physical health are inter-related. The ancient concept, a sound mind in a sound body has been rehabilated. Poor mental health affects physical health and vice versa. Psychological factors are considered to play a major role in disorders such as hypertension, peptic ulcer and asthma. Some major mental illnesses such as depression, and schizophrenia have both psychological and biological components.

Some characters of Mentally Healthy Person pointed out by psychologists are:

a. a mentally healthy person is free from internal conflicts; he is not at "war" with himself.

b. He is well-adjusted, i.e., he is able to get along well with others. He accepts criticism and is not easily upset.

c. He searches for identity.

d. He has a strong sense of self-esteem.

e. He knows himself: his needs, problems and goals (this is known as self-actualization).

f. He has good self-control-balances rationality and emotionality.

g. He faces problems and tries to solve them intelligently, i.e., coping with stress and anxiety.

Assessment of mental health at the population level may be made by administering mental status questionnaires by trained interviewers.

(c) Social Dimension

Health cannot be isolated from social and cultural context. A person's health is inextricably related to everything surrounding him. It is an established fact that it is not possible to raise the level of a people's health without changing their social and cultural environments. For example, people obviously cannot be healthy if they cannot afford necessities of food, clothing and shelter, nor can they be healthy in countries of extreme political oppression where basic human rights are denied. Women cannot be healthy when their contribution to society is undervalued, neither blacks nor whites can be healthy in a racist society where racism undermines human worth, self esteem and social relationships. Unemployed people cannot be healthy in a society which only values people in paid employment, and it is very unlikely that anyone can be healthy in an area which lacks basic services and facilities such as health care, transport and recreation. Michael Wilson puts this graphically when he says that health cannot be possessed, "It can only be shared. There is no health for me without my brother. There is no health for Britain without Bangladesh". Thus social health takes into account that every individual is a part of a family and of wider community and focuses on social and economic conditions and well-being of the "whole person" in the context of his social network.

(d) Spiritual Dimension

This is the ability to establish peace and harmony in our lives. Being spiritually healthy does not mean that person have to be religious. Some find their spiritually through nature, meditation, reciting affirmations or yoga. This for some people is connected with religious beliefs and practices; for others it is to do with personal creeds, principles of behavior and ways of achieving peace of mind and

being at peace with oneself. It is the intangible something that transcends physiology and psychology. Plato lamented: "For this is the error of our day that physicians separate the body from soul". This is even true today. The importance of this aspect of health can hardly be overemphasized.

(e) Emotional Dimension

It is the ability to understand ourselves and cope with life's challenges. It is our emotional reaction to life. This dimension of focuses on acknowledgment of feelings such as anger, fear, hope, love and happiness. Optimists have strong emotional health compared with pessimists.

Historically the mental and emotional dimensions have been seen as one element or as two closely related elements. However, as more research becomes available a definite difference is emerging. Mental health can be seen as "knowing" or cognition while emotional health relate to "feeling".

(f) Vocational dimension:

Vocational health is one's attitude about work and career. This dimension involves preparing for and participating in work that provides personal satisfaction and life enrichment. This includes continued development of occupational skills, finding balance between work and leisure activities, and finding challenging work.

The importance of this dimension is exposed when individuals suddenly lose their jobs or faced with mandatory retirement. For many individuals, the vocational dimension may be merely a source of income. To others, this dimension represents the culmination of the efforts of other dimensions as they function together to produce what the individual consider life "success".

(g) Others

A few other dimensions have also been suggested such as:

- Philosophical dimension
- Cultural dimension
- Socio-economic dimension
- Environmental dimension
- Educational dimension
- Nutritional dimension

- Curative dimension
- Preventive dimension

POSITIVE HEALTH

Broadly Health does not merely mean the absence of disease or provision of diagnostic, curative and preventive services. The WHO has, therefore, rightly stressed in its definition of health a "state of complete physical, mental and social well-being".

The state of positive health implies the notion of "perfect functioning" of the body and mind. It conceptualizes health **biologically,** a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body **psychologically,** a state in which the individual feels a sense of perfect well-being and of mastery over his environment, and **socially,** a state in which the individual's capacities for participation in the social system are optimal. These ideas were widely ventilated some years ago but now appear slightly ridiculous.

Positive health will, therefore, always remain a mirage because everything in our life is subject to change. Health in this context has been described as a potentiality __ the ability of an individual or a social group to modify himself or itself continually in the context of changing conditions of life.

Recently, a broader concept of health has been emerging __ that if improving the quality of life of which health is an essential component. This at once brings to focus that positive health depends not only on medical factors, but also on all the other economic, cultural and social factors operating in the community.

HEALTH – A RELATIVE CONCEPT

An alternative approach, to positive health, conceptualizes health not as an ideal state, but as a biologically "normal" state, based on statistical averages For example, a newborn baby in India weighs 2.8 kg on an average compared to 3.5kg in the developed countries, and yet compares favorably in health. The height and weight standards vary from country to country, and also between socio-economic groups. Many ordinary people show heart murmurs, enlarged tonsils and X-ray shadows in the chest and still do not show the signs of ill health. Thus health is a relative concept and health levels vary among cultures, social classes and age-groups. This shows that health in any society should be defined in terms of widespread ecological conditions.

That is, in place of setting universal health standards, each country will decide on its own norms for a given set of widespread conditions and then look into means to achieve that level.

SPECTRUM OF HEALTH

Health and disease lie along a continuum, and there is no single cut-off point. The lowest point on the health-disease spectrum is death and the highest point corresponds to the WHO definition of positive health (fig.1.0). In this way it is obvious that health fluctuates with in a range of optimum well-being to various levels of dysfunction, including the state of total dysfunction, namely the death. The transition from optimum health to ill health is often gradual, and where one state ends and the other begins is a matter of judgment.

The spectral concept of health emphasizes that the health is not static; it is a dynamic fact and a process of continuous change, subject to frequent complex variations. What is considered maximum health today may be minimum tomorrow. That is, a person may function at maximum levels of health today and low levels of health tomorrow. It suggests that health is a state not to be attained once and for all, but ever to be renewed. There are degrees or "levels of health" as there are degrees or severity of illness. As long as we alive there are some degrees of health in us.

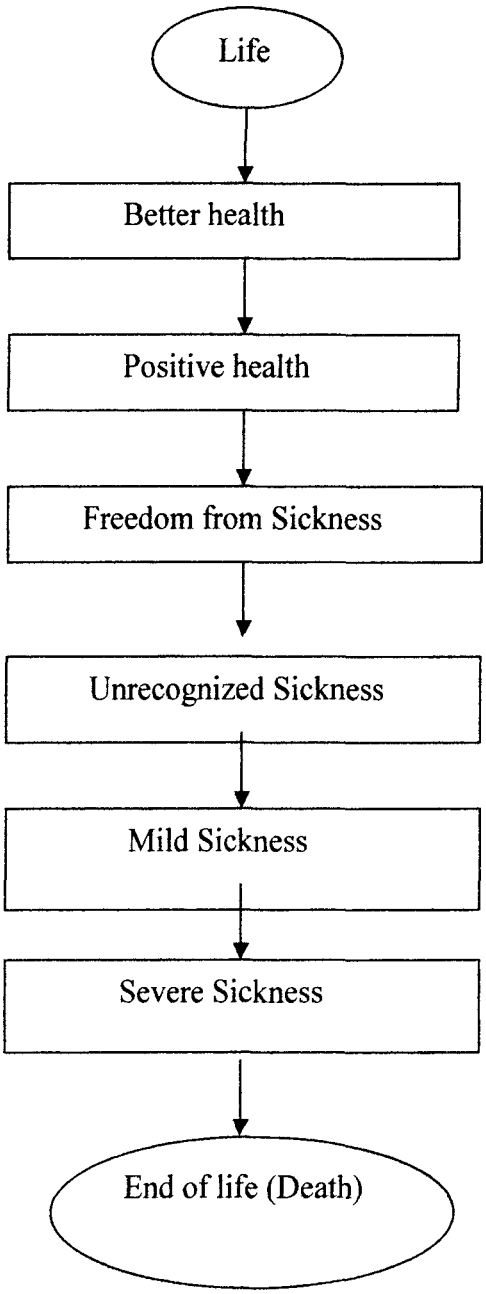

Fig.1.0: The Health Sickness Continum

DETERMINANTS OF HEALTH

In the past three decades, basic and applied research across a range of substantive areas has affirmed the value of the biopsychosocial perspective and demonstrated how biological, psychological and social processes operate together to affect physical health outcomes (Baum & Posluszny, 1999; Cohen, 1998; Salovey, Rothman & Rodin, 1998; Taylor, Repetti & Seeman, 1997). Beside biopsychosocial

variables, macro variables e.g., age, gender, income, education are also included in the multiple systems.

(a) Biological

To represent the biological cluster of health, several variables were also tested in the studies, e.g., self-reported health, that is, physical health and functioning. As this has been found to be correlated with objective measure of health, such as, physicians' assessment (Blazer & Houpt, 1979; Mossey & Shaprio, 1982; Idler & Angel, 1990; Szaflarski & Cubbins, 2004). IN case of ill health, information on acute and chronic condition were also obtained along with reporting of family linkage endorsement. Physical/Somatic symptoms and complaints and psychological distress were also taken into account.

Body mass index, blood pressure, blood sugar, hemoglobin level, blood grouping, pulse rate and skin temperature were also included. These variables are important not only to study health behaviour but also for interventions, such as losing weight and exercise when blood pressure is elevated. Advice regarding food and nutrition can help in case of poor hemoglobin level and abnormal lipid profiles. The way people think about health and wellness too influence their health and wellness behaviour (Hughner & Kline, 2004; Lawton, 2003).

Proper physical and psychological functioning is also considered to be indicator of being healthy (Mc Kague & Verhoef, 2003).

(b) Psychological

Among the psychological factors, recent researches show a major change of focus from negative to positive factors. Hope and optimism are the positive conditions of human strength which include the positive cognitive, emotional and motivational states. In the past two decades, research has shown that optimism, in face of crisis, make people expect good things to happen and achieve better outcome (Scheier, Carver and Bridges, 2000). Optimism may promote longevity, Physical well-being and health promoting behaviour (Peterson, 2000; Peterson, Seligman, Yurko, Martin & Friedman, 1998; Scheier & Carver, 1992).

Peterson (2000) has suggested that religious thought could nurture certain aspects of optimism especially as a known specific positive expectation (Tiger, 1979)

because such aspect of expectation promote general state of vigour and resilience which may lead to desirable outcome in face of drastic condition, such as, illness. Psychologists studying faith phenomenon have also suggested that faith offers a sense of meaning and purpose (Hood et. Al., 1996), enhances long range hope and generates optimism for near future (Myer, 1992). Sethi and Sligman (1993) reported a positive relationship between religiosity (even fundamentalism), optimism and hope (Ai,. Peterson & Huang, 2003; Ai et al., 2004).

(c) Social

A growing array of environmental and personality characteristics have been identified in epidemiological research as risk factors for physical illness and premature death. For example, individuals who are socially isolated or report low level of social support are at increased risk of cardiovascular disease, cancer, and premature death (House, Landis & Umberson, 1988). High level of job stress also place people at gender risk of illness (Schnall, Landsbergis & Beker, 1994), as does the chronic stress of caring for seriously ill family members (Schulz & Beach, 1999). Individuals who are prone to anger and hostility are at increased risk of developing cardiovascular disease and premature death, as are people who report symptoms of anxiety, depression, pessimism and hopelessness (Smith & Gallo, 2001).

People who are socially isolated, experiencing high level of job stress, or are prone to negative emotions may be likely to smoke more, overeat, consume too much alcohol, or avoid regular exercise. These health behaviours could account for some of the effects of the social environment and personality on health. However, the association of these psycho-social risk factors with subsequent morbidity and mortality remains significant even when the effects of health behaviour are controlled (Adler & Mathews, 1994). The prevailing view in this research area is that psychological effect of stressful environment and negative emotions are the link between psychological risk factors and subsequent disease. These mechanisms are best understood in two general pathways __ the effect of stress on cardiovascular system and its effect on immune system (Rozanski, Blumenthal & Kaplan, 1999).

Psychosocial factors identified in epidemiological studies as risk factor for cardiovascular disease tend to be related to psycho-physiological mechanism. For example, social support generally reduced the magnitude of stress induced

physiological reactivity (Uchino, et.al. 1996), and personality characteristics associated with increased risk of cardiovascular disease such as hostility. These are associated with more pronounced cardiovascular and neuro-endocrine reactivity (Smith & Gallo, 2004)

The third major aspect in health psychology involves the impact of psychosocial aspects and interventions on acute and chronic medical illness such as pain, disability, emotional distress, and the usefulness of psychological interventions. Psychological interventions facilitate to cope with chronic disease (e.g., arthritis, headache and chronic back pain) and stress, and aim to improve health.

(d) Environmental

Environmental threats and demands evoke transient increase in heart rate, blood pressure, and concentration on various hormones (e.g. epinephrine, nor-epinephrine, cortisol, etc.). In human and animal research, over a period of time, these stress induced physiological changes appear to promote more enduring levels of high blood pressure: , initiate and hasten the development of atherosclerosis in the coronary and carotid arteries. Atherosclerosis in these sites increases the risk of coronary heart disease and stoke respectively. Environmental stresses and the brief psychogenic changes they evoke can also precipitate acute manifestation of cardiovascular disease (e.g., temporary reduction of oxygen supply to heart muscle) among individuals with pre-existing atherosclerosis (Rozanski, et.al.1999).

(e) Ways of Living

Health is a way of life. It is related deeply to life style which includes ways of living, personal hygiene, habits and behviour. These life activities are the experiences engaged in by the individual. These experiences determine the way he lives, which to a large extent produce the quality of life and the degree of effective living. Experiences can be classified as physical, mental, social and spiritual. They include what the individual does each day__ his work, his play, his sleep and rest, his expression of faith __ all his health practices determining his way of living. The selection of wholesome experiences and adoption of a balanced program of activities will surely exert a powerful influence on the quality of life and consequently ensure good of health.

Currently, the major health problems in the developed countries are tied significantly to life style, viz., cardio-vascular disease, automobile accidents, drug and alcohol abuse, suicides and homicides. In order to change for the better it will require education to change life style and behavioural pattern. Fruedenberg (1978) suggested a strategy called "Health Education for Social change".

(f) Socio-economic Conditions

Socio-economic conditions have long been known to influence human health. The health of a community is integrally related to its economic status and its social and political organization. The world today is divided into rich and poor, developed and undeveloped, haves and haves-not. There is little doubt that in many developed countries, it is the economic progress that has been a major factor in reducing morbidity, increasing life expectancy and improving quality of life.

It is said that poverty leads to sickness and sickness to poverty, one of the mankinds' vicious cycle. The teeming millions of india's population, which has now crossed the one billion mark, live in rural areas in abject poverty. They are infact below the poverty line. The striking features of the rural life of our country are insanitary living conditions, malnutrition, lack of safe drinking water__ all responsible for poor health. It is an established epidemiological finding that the prevalence and distribution of disease is strongly influenced by economic factors. Infact, most of the infectious and nutritional deficiency diseases, common in developing countries, are really "diseases of poverty". Poverty disposes to high maternal, child and infant mortality rates. Poverty also predisposes to crime, violence, drug abuse, depression, and other forms of deviant behaviour.

The very state of being employed in productive work promotes health, because the unemployed usually show a higher incidence of ill health and death.

Ironically, affluence may also be a contributory cause of illness as exemplified by a high rate of coronary heart disease, diabetes in the upper socio-economic groups. The major medical causes of death in the west today are cardiovascular disease and cancer which together accounts for two-thirds of all deaths.

Health is also related to the country's political system. Often the main obstacles to the implementation of health technologies are not technical, but rather

political. If poor health patterns are to be changed, then changes must be made in the entire sociopolitical system in any given community.

(g) Health Services

Health services include all those personal and community services including medical care, which are directed towards the protection and promotion of the health in the community. They range from preventive to curative measures, including health guidance, periodical health examinations, recording of health histories, and clinical, surgical and hospital care. The purpose of health services is to improve the health status of population. For example, immunization of children will have a powerful impact on the incidence and prevalence of particular diseases. Provision of safe water can prevent mortality and morbidity from water-borne diseases. The care of pregnant women and children would contribute to the reduction of maternal and child morbidity and mortality. The importance of all these services can hardly be over-emphasized in ensuring good health of the community.

The World Health Organization has taken a leading role in action for health promotion in the 1980s and 90s. WHO stated in 1977, at the 30th World Health Assembly that the main social target of governments and WHO in the coming decades should be the attainment of all citizens of the world by the year 2000 of a level that will permit them to lead a socially and economically productive life. This was the beginning which has come to be known as the "health for all" movement which led to the development of regional strategies for different regions of the world in 1980s.

The regional strategy called for fundamental changes in the health policy of member countries, including a much higher priority for health promotion and disease prevention. It is known for not merely the health services but all public sectors with a potential impact on health to take positive steps to maintain and improve it. Specific regional targets were set and published in 1985. This gave impetus to the new interest in health promotion activities during the 1990s with emphasis on addressing inequalities in health through attention to the key social, economic and environmental determinants of ill-health and on community participation in health promotion. These moves are all positive indicators of a concern to address inequalities in health and deal with root causes of ill-health in today's society.

MODELS OF HEALTH

Health Belief Model

This was developed by four psychologists' – Hochbaum, Kegeles, Leventhal and Rosenstock (Rosenstock, 1974) to predict individuals' preventive health behavior. It was later on modified by becker and maiman (1975) incorporated sick-role behavior and compliance with medical regimens. Readiness to take action and engage in health related behavior depends on a number of factors. The first two are concerned with the extent to which individuals feel vulnerable to a particular illness. This involves whether they feel susceptible to contracting the illness and their thoughts about how severe it is. Besides, susceptibility, severity, and vulnerability and other factors involved in the model are benefits (potential to be gained from a particular course of action), barriers (degrees of physical, psychological or financial distress associated with any form of action) and cues to action (stimuli that trigger appropriate health behavior). Various factors such as demographic, ethnic, social; and personality traits may also influence health behavior.

Becker et al. (1977) included yet another factor in their revision of the model, which is the predisposition or motivation of the people to engage in health-related practices. Becker et al. (1977) stated that the health belief model is a useful tool in predicting the degree to which individuals are likely to play an active role in their and others' health care.

Stated simply the Health Belief Model examines the extent to which a person sees a problem as having serious consequences and a high probability of occurrence. The model is basically a psychological cost-benefit analysis in which action follows motives that are most salient and perceived as most valuable when the person has conflicting motives. The model also gives attention to cues to action because investigations show that activating stimuli are necessary to bring about the necessary actions among motivated persons. It is also helpful if persons have a clear plan for translating their motives into action. Likelihood for desired actions are enhanced when the person has comprehensible instructions on how to engage in the desired behavior without vastly splitting usual daily routines. Preventive action is more likely to take place if it is successfully be integrated with routine behavior. For example, members of some religious groups have good health practices associated

with their religious beliefs. Their better health outcomes occur not so much because health is given special emphasis but more because behaviors associated with religious beliefs promote good health.

There is no doubt that the Health Belief Model can be a useful guide to health behavior under certain circumstances (Rosenstock, 1974; Rosenstock and Kirscht, 1979), but there are a number of criticisms. Firstly, the reformulations by Becker and Maiman (1975) make the theory unnecessarily unwieldy with 11 "readiness" factors and 23 enabling factors. This clearly constitutes more variables that can be included in any one study (Wallston &Wallston, 1984). Secondly, the model treats people as rational decision makers. Janis (1984) says, "The important point is that the health belief model, like other models of rational choice, fails to specify under what conditions people will give priority to avoiding subjective discomfort at the cost of endangering their lives, and under what conditions they will make a more rational decision". Finally, Wallston and Wallston (1984) think that combining the health belief predictors interactively may prove more fruitful than simply adding them together.

Locus of Control Model

Rotter (1954) proposed that behavior was a function of the individual's belief that the behavior will lead to reinforcement (expectancy) and how much that reinforcement is liked (reinforcement value). The significant factor in determining generalized expectancies is locus of control. To measure these generalized expectancies, almost a dozen different locus of control measures have been developed (Lefcourt, 1982), but the test that Rotter devised is known as the I-E Scale.

We have an external locus of control if we believe that we are not masters of our own fate and are subject to the control of outside forces, such as luck or destiny (e.g., such beliefs that many people can be described as victims of fate; most of the things that happen to us are a matter of luck). However, we have an internal locus of control if we believe that we have ability to influence and determine the features that affect our lives (e.g., beliefs such as __ What happens to other people is very much of their own making; we are in complete control of our own destiny).If we have an external locus of control, we are less likely to engage in behaviors that could have a

positive effect on our health or lives, believing that it does not matter what we do, fate has already decided for us. But if, on other hand, we have an internal locus of control, then we are much more likely to do things for ourselves because we believe that we can have a significant say in how our life is run.

And increasing number of health researches have measured locus of control beliefs and have tried to relate these expectancies to a host of health related behaviors (Obrele, 1991). Some of these studies used a scale where there was no mention of health factors (Lavenson, 1973); others have incorporated specific health items into their scale (Wallston and Wallston.1984). Some studies have found that a person is most likely to engage in health behavior if he has a belief in internal locus of control and a high valuing of health; others have found the opposite to be true.

There are number of drawbacks to this approach. Firstly, its predictive value is not as reliable as the health belief model (Wallston and Wallston, 1984).Secondly, the prediction of behavior from attitudes requires a high degree of correspondence; it is doubtful whether the model can accommodate such difficulties. Stainton Rogers (1991) thinks the model is totally inappropriate as an explanation of health behavior. However, Obrele (1991) thinks that the main problem has not been with the locus of control itself but the standard of studies that have used the model. Finally, it may be more profitable to examine other constructs as well as locus of control that are defined by specific situation.

Conflict Theory Model

This is a model of personal decision making that attempts to specify the conditions under which individuals will give priority to avoiding subjective discomfort at the cost endangering their lives, and under what conditions they will make a more sensible decision by seeking out and taking into consideration the available medical information about the real consequences of alternative courses of action in order to maximize their chances of survival Janis (1984). Janis and Mann (1977) have proposed five different patterns of coping with realistic threats and five stages that individual go through in order to arrive at a firm decision. These five coping patterns of the decision are described below:-

1. Unconflicted Persistence: Ignoring the information about risks, the person continues to behave in a complacent fashion.

2. Uncomplicated Change: Accepting without question and adopting whatever course of action is recommended.

3. Defensive Avoidance: Evading the issue by putting things off, shifting the responsibility to someone else or selectively attending to the sorts of information one wants.

4. Hyper Vigilance: Due to a feeling of impending doom the person becomes so panicky that he jumps at the first solution that appears to provide the answer, without considering the other courses of action.

5. Vigilance: The individual carefully considers all the course of action in an unbiased manner before taking a decision for good reason.

According to Janis and Mann (1977), the fifth pattern 'vigilance' is a prerequisite of decision making. All the other four lead to maladaptive behavioral consequences. In order to put the vigilance pattern into operation three conditions must be satisfied: (1) awareness of serious risks for whatever alternative is chosen; (2) hope of finding a better alternative; and (3) belief that three is adequate time for search and deliberation before a decision is taken. If condition one (conflict) is not met, uncomplicated adherence or unconflicted change would follow in all likelihood. If the second condition (hope) is not met, defensive avoidance will be the dominant coping pattern. If the third condition (adequate time) is absent, hypervigilance will inevitably follow as the dominant coping pattern.

When all these criteria are satisfied, the decision maker is now in a position to proceed through the stages of making a stable decision which include appraising the challenge; surveying alternatives; weighing alternatives and taking a decision; developing a plan to implement the decision and informing interested parties about the same; and adhering to the decision (commitment) despite negative feedback of any new threats or opportunities which are discounted.

Most significant feature of the theory is the emphasis on the coping pattern of vigilance. If any of the other coping pattern is dominant, then the decision maker will fail to engage in adequate information search and appraisal of consequences,

overlooking or ignoring crucial information about relevant costs and benefits. Under these conditions the outcome will not be correctly predicted by the Health Belief Model or by any other rationalistic model of decision making (Janis, 1984). The model has not been tested, but Milner (1994) successfully used the model in a study of decision making processes in self help groups. Group structure was not only related to decision making but to self-esteem as well.

Healthy body and healthy mind are a prerequisite of all meaningful existence. Man being a social animal needs to participate in social life for which he needs a role and the role implies physical energy, the source of which is a healthy body. Healthy mind is required to govern and appreciate one's social action and to maintain mental peace and self-confidence. Health and wellbeing is also an important factor in the life of the elderly as it affects almost every single aspect of life and determines what activities or tasks one engages in or not, and the likelihood of which tasks or activities one is able to complete successfully. Poor Health can make one dependent on others even for the basic necessities of life and this can affect one's perception of oneself. In essence, health seems to be one of the most significant factors affecting well-being and happiness in old age.

The Indian Society has experienced far reaching changes in its social, economic and political set up. It has changed from an agricultural to an industrial economy, from a society governed by emperors and monarchs to a democratic one, from a society based on caste to society which aims to guarantee equality of opportunity to every citizen. Negative impact of changing society on elderly well-being is increasing loneliness and alienation. Elderly are sadder and depressed in the materialistic world and feeling of insecurity is due to lack of moral support from adult children, and emotional and physical distancing from them. Saraswati (1979) concluded in his study that the old age has started emerging as the social problem in Indian society due to the social-cultural changes brought by Revolution. Rao (1979) observed that because of better health facilities people live longer in India and its typical socio-economic conditions like poverty, breaking up joint family system and care of aged person posed a threat to them. While the increasing number of elderly is attributed to demographic transition, their deteriorating condition is considered as a result of the fast eroding traditional family system in the wake of modernization and urbanization.

Undoubtedly, there are unbreakable bonds with family. The traditional nature of Indian family, where sons are supposed to take care of their parents, the bond of relationship between young and old generation is unbreakable. The constitution of India also has made a provision that the state shall provide for public assistance in the case of old age. Article 41 of the constitution of India reads as under: ***"the state shall, within limits of its economic capacity and development matter effective provision for securing the right to work, education and to public assistance in case of unemployment, old age, sickness and disablement, and in the other cases of undeserved want."*** But young children are no doubt drifting away but middle aged people are still not ready to shed their elderly from their lives and bear them willingly or unwillingly. Many of them may be given discarded corner of the house, but are not sent to old age homes. Although many elderly widowers are findings their ways in old age homes, elderly women do not shift. This is mainly because of feeling or emotion insecurity, emotion bond with children and because she may still be useful to daughter-in-law in rearing children and doing household chores.

In view of the importance of the issue, further research is needed to investigate the role of other personality variables in affecting health of the individual in general and elderly people in particular. Thus the present study is designed to examine the effect of very important personality variable i.e. Loneliness on the health of elderly people.

LONELINESS

Loneliness is an emotional and cognitive reaction to having fewer and less satisfying relationships than one desires (Archibald, Bartholomen & Marx, 1995; Peplau & Perlman, 1982). In Understanding loneliness, keep in mind that it is a subjective experience, reflecting what we feel and think about our interpersonal life, and it is not the same thing as solitude or being alone. We can spend long periods of time alone without feeling lonely, and we can also feel terribly lonely in a crowd. The partners in a long marriage can experience loneliness, whereas a recently widowed person may not feel lonely (Tornstam, 1992). Infact, research has shown that lonely and nonlonely people do not differ in the quantity of their social interaction, but rather in the quality of such exchanges. Lonely people spend more time with strangers and acquaintances and less time with friends and family than those who are not lonely

(Jones et.al., 1985). Loneliness is the inability to maintain the level of affiliation one desires. Loneliness is more than a feeling of wanting company or wanting to do something with another person. Loneliness is a feeling of being cut off, disconnected and alienated from other people. The lonely person may find it difficult or even impossible to have any form of meaningful human contact. Lonely people often experience a subjective sense of inner emptiness or hollowness, with feeling of separation or isolation from the world.

DEFINITIONS OF LONELINESS

Different researchers have given different definitions of loneliness. Following are some examples:

Loneliness is "an estrangement from oneself and from others, a feeling of alienation, even in the midst of others" (J.de Jong-Gierveld and J. Raodschelders)

Loneliness is "an incredible intensity and pain that obliterates the memory of past relationships and spills over into the future" (S. Gordon)

Loneliness is "a barrier that prevents one from uniting with the innerself" (C. Rogers)

Loneliness is an "unpleasant, painful, anxious yearning for another person" (J. J. Ponzetti)

Loneliness is "the absence of an adequate positive relationships to persons, places or things" (Brage and Meredith)

K.Rook defined "Loneliness as an enduring condition of emotional distress that arises when a person feels estranged from, misunderstood or rejected by others and/or lacks appropriate social partners for desired activities, particularly activities that provide a sense of social integration and opportunities for emotional intimacy".

According to Vicki "Loneliness is a feeling that no one wants you and frustrating because you don't know why?

Jasmine defined "Being in a place or situation and yet being totally detached from it. And there is this huge yawning space inside you crying out to you".

Loneliness is the "Ultimate form of poverty" (Hans Koresh)

According to William "Loneliness is a living death".

Peter says that "loneliness is a sharp and cold claw that squeezes your heart with amazing strength; and when it's shattered into pieces, and every single part of your body weights like tons of lead, people see in you nothing but a sleepy face, not caring on going deeper into your state... they don't even want to know you're feeling like hell..."

Similar to social anxiety, we can conceive loneliness as both a short-lived state and a chronic, long-term trait. For example, when a student first arrives on campus as a fresher, he may experience a temporary sense of loneliness until he becomes integrated into the college community. In contrast, some people suffer from chronic loneliness, regardless of the length of time spent spend becoming acclimated to new social settings. Although loneliness is a subjective experience, social psychologists have developed objective measures to identify lonely people. One of the more commonly used measures is the UCLA Loneliness Scale (Russell et al.. 1980) which asks people to indicate how often they experience such feelings.

Two distinct forms of loneliness exists, emotional isolation and social isolation (Peplau & Perlman, 1982). In **emotional isolation**, person feels a lack of deep emotional attachment to one specific person whereas people who experience **social isolation** suffer from a lack of friends, associates, or relatives (Dugan & Kivett, 1994)

The two types of loneliness often do not go hand in hand. For example, an individual may have many friends and acquaintances and a large extended family, yet lacks any single person with whom to share a deep relationship. Similarly, people who frequently attend parties or eat in crowded cafeterias with many others may still experience a sense of loneliness if they feel emotionally detached from the people who surround them. Although they might not feel socially isolated in such cases, they may experience emotional isolation (Russell et al; 1984; Bell, 1993)

Mostly everyone experiences loneliness, recovery from it often depends on how we interpret and react to its perceived causes (Anderson et al; 1994). In an examination of the duration of loneliness experienced by first-year college students, Caorlyn Cutrona (1982) found that it lasted longer among those who initially blamed themselves for their social isolation. That is, the chronically lonely persons make significantly more internal, stable attributions for their loneliness (for example, "I' m

too shy" or "I don't know how to start a new relationship") than those who overcome their sense of isolation. This sort of self-blaming can discourage people from seeking out others and can perpetuate their dissatisfaction with social relationships. On the other hand, Cutrona found that those who thought of loneliness as being caused by a combination of personal and external factors (for example, "I'm lonely because I don't know anyone here. Things will get better as I meet others") seemed to be more hopeful that they could make things change for the better. True to what would be expected from attribution theory, these external, unstable attributions resulted in relatively short-lived loneliness for most of these students.

Loneliness may be regarded as a 'geriatric giant', leading to impaired quality of life, greater need for institutional care and increased mortality. For the past 30 years, a growing number of studies have focused on loneliness. However the majority of these have been descriptive and cross-sectional. Further longitudinal studies are needed to understand the casual relationship between life-events and loneliness, its prognostic significance and, in particular, whether negative consequences may be alleviated.

Loneliness is a common feeling among older people. Prevalence has been investigated in numbers epidemiological studies, with the proportion of lonely individuals ranging from a few percent to 40 percent.

According to a Euro barometer study conducted few years ago and involving 604 adults, from across Europe, the proportion 'often feeling lonely' varied widely between countries. The proportion was highest in Greece (36%) and in Portugal (23%) and lowest in Denmark and Sweden (4-6%). The proportion varied from 7 to 9 percent in Germany, the Netherlands and the UK, and from 10 to 17% in Belgium, France, Ireland, Luxemburg, Spain and Italy. (Walker A. 1993; Anderson L, 1998).

In a Dutch survey ($n = 3823$, age, range 54 -89 years), 4% reported feeling 'very lonely' and 28% 'moderately lonely' (Van Tilburg TG, De Jong Gierveld J. 1999). In a swedish study, a third (35%) of the older people ($n = 1725$, age > 75 years) feet lonely 'at least sometimes' (Holmen K, Ericsson K, Anderson L. Wimblaad B. 1992; Holmen K, 1994). Another Nordic study found that 36% of older Finns ($n = 1037$, age 60 and over) experienced loneliness 'often or sometimes' (Vaarama M, Hakkarainen A, Laaksonen S. 1998). An American study of survey of very old rural

adults (n = 119, mean age 83 years), reported that 21% felt lonely 'quite often', whereas 43% felt this way 'sometimes' (Dugan E, Kivett VR 1994).

Several explanations have been proposed for the great variations in reported prevalence. Firstly, some people may be reluctant to identify themselves as lonely because of the stigmatization of loneliness. Secondly, the form of questions, their wording and their context may guide the respondents' answers (Anderson L. 1998). Rokach and Brock (1997) suggested that it is easier to speak about loneliness experienced in the past than about existing loneliness. Jylha and Jokela (1990) proposed that feelings of loneliness are most prevalent in communities that are most integrated, and weakest in communities in which individuality is emphasized. Their assumption was based on the barometer study in which older people's feelings of loneliness were more common in the rural areas of Greece than in Finland, even though in Greece, the respondents seldom live alone, contrary to the situation in Finland.

In order to understand what loneliness in elderly people actually means, it is necessary to distinguish between objective and subjective loneliness. The former refers to the absence of company, either temporary or permanent; in other words it involves those people who are alone. This type includes those people who do not live with anybody, and they account for 14% of the total of elderly people who live in their homes. Among the elderly the tendency to live alone is a function of the person's gender, marital status and the size of the town or city they live in. Women live alone (20%) more frequently than men (7%); elderly people who are separated or divorced (55%) form the largest group of people living alone.

Objective loneliness does not always mean an unpleasant experience: it may become a sought after and enriching experience. Most elderly people living alone, however, have been compelled to do so. Fifty-nine percent of them declare that they have been led to do so, though they have learned to adapt; 36% prefer to live alone; 55% would like to live with their children or their families. Loneliness is more highly valued when it is temporary. Elderly people can find the moments they need to attend to their personal affairs, knowing that after a few moments of "withdrawal" they can count on other people's company.

Subjective loneliness, on other hand, is undergone by those people who feel lonely. It consists of a feeling and one which is feared by 22% of the elderly. Consequently, it is never an intended situation __ as objective loneliness might be __ but is always enforced by the individual's personal situation. The feeling of loneliness increases with age. 27% of the people in the 65-69 age group declare that they feel alone, and the percentage rises to 36% for people in the over 80 age group. As with objective loneliness, gender and marital status have an effect on the feeling of loneliness. This can be seen in the statements made with respect to feeling a certain degree of loneliness: More women (39%) than men (21%) feel lonely. People who have separated (68%) as well as unmarried and widowed people (39%) have a higher tendency to feel lonely than married people (17%).

Even though we have distinguished objective loneliness from subjective loneliness, the two are related. Out of the people who live alone, 38% feel miserable because of loneliness, while among those who live in the company of others the figure reaches only 8%.

DISTINCTION AMONG LONELINESS, SOCIAL ISOLATION AND DEPRESSION

Loneliness is not the same as being alone. Many people have times when they are alone through circumstances or choice. Being alone can be experienced as positive, pleasurable, and emotionally refreshing if it is under the individual's control. Solitude is the state of being alone and secluded from other people, and often implies having made conscious choice to be alone. Loneliness is therefore unwilling solitude.

In their growth as individuals, humans start a separation process at birth, which continues with growing independence towards adulthood. As such feeling alone can be a healthy emotion and, indeed, choosing to be alone for a period of solitude can be enriching. To experience loneliness, however, can be to feel overwhelmed by an unpleasurable feeling of separateness at a profound level. This can manifest in feelings of abandonment, rejection, depression, insecurity, anxiety, hopelessness, unworthiness, meaninglessness, and resentment. If these feelings are prolonged they may become debilitating and prevent the affected individual from developing healthy relationships and lifestyles. If the individual is convinced he or/ she is unlovable, this will increase the experience of suffering and the likelihood of

avoiding social contact. Low self-esteem will often trigger the social disconnection which can lead to loneliness.

In some people, temporary or prolonged loneliness can lead to notable artistic and creative expression, for example, as was the case with Emily Dickinson. This is not to imply that loneliness itself ensures this creativity; rather, it may have an influence on the subject matter of the artist.

The term loneliness, social isolation, and living alone are often used interchangeably, although they are distinct but interrelated concepts. In addition, depression is also closely related to loneliness. A person may suffer from loneliness even though surrounded by many people, while an isolated person may feel completely content with their situation. Living alone is the most straight forward concept, which may be measured easily by household size (Victor C, Scambler S, Bond J, Bowling A. 2002) where as social isolation relates to number of contacts and the integration of an individual into the surrounding social environment (Cattan M, White M. 2003). So far loneliness is a subjective feeling and the amount of it can only be described by the individual experiencing it (Andersson L. 1998; Wenger GC, Davies R, Shahtamasebi S, Scott A. 1996; Tilvis RS, Pitkala KH, Jolkkonen J, Standberg TE. 2000). Valid measures of mood and of the number of social contacts have been available for a long time. Therefore longitudinal research on depression and social isolation has been extensive and their prognostic significance in old age is well known (Sugisawa H, Liang J, Liu X. 1994; Fratiglioni L, Wang HX, Ericsson K, Maytan M, Winblad B. 2000). However distinguishing social isolation and depression fro loneliness is importrant, because loneliness seems to have independent prognostic significance (Tilvis RS, Pitkala KH, Jolkkonen J, Standberg TE. 2000); Russell DW, Cutrona CE, de la Mora A, Wallace RB 1997). In addition, the approach to treatment and intervention in these three domains should be different. For instance, people feeling lonely do not necessarily benefit from antidepressants or fro people visiting them.

Loneliness may be a positive, voluntary and expected situation (solitude), and a precondition for creative working (Andersson L. 1998; Tornstam L. 1990). It may also be a negative, distressing feeling (Larson R, Zuzanek J, Mannell R. 1985). Tornstam distinguished three dimensions in the feeling of loneliness: intensity/ quality

of loneliness, inner loneliness and positive loneliness. The intensity of loneliness is higher among young subjects, whereas the prevalence of inner loneliness is slightly higher among older adults.

Victor et al (2000) reviewed four major theories of loneliness. This existential theory derives from Christanity, and sees that in life's most intimate moments, the individual is always alone. The psychodynamic theory emphasizes that the experience of loneliness is based on the early, emotional relationships of an individual and on the development of interpersonal attachments. While psychodynamic theory focuses on the pathological features of loneliness, in the existential theory, loneliness may be seen as a positive opportunity. (Victor C, Scambler S, Bond J, Bowling A. 2000). The cognitive theory focuses on the individual's own responses to and experiences of loneliness, which depend on the individual's own self-esteem and the standards they set for themselves. Therefore loneliness may be manipulated by interventions that raise self-esteem and develop social skills. The interactionist theory is based on the attachment theory of bowlby, combining the two elements of loneliness: emotional loneliness and social aspects accompanying loneliness. Both can be evaluated in terms of the quality and quantity of loneliness (Victor C, Scambler S, Bond J, Bowling A. 2000); Donaldson JM, Watson R. 1996; Mayers AM, Khoo S-T, Svartberg M. 2002).

Thus, the concept of loneliness is complicated and is pregnant in meanings. The researcher's philosophical point of view will have a significant impact on hypotheses, theories, methodology and results of studies in this field. Furthermore, when studying the inner feelings of human beings, it is important to know more about the meanings people themselves attach to the concept. However, few qualitative studies have been conducted to explore this issue.

COMMON SYMPTOMS OF LONLINESS

(a) Believing that 'everyone else' has friends

(b) Feeling socially inadequate and socially unskilled

(c) Being convinced that there is something wrong with you

(d) Feeling that no one understands one's situation

(e) Feeling reluctant to attempt to change, or try new things

(f) Feeling 'empty', depressed, or even contemplating suicide

(g) Feeling anxious and/or desperate

Apart from above eight other different symptoms associated with loneliness. These are discussed below:

(1) **Painful:** Loneliness is painful. Without a doubt, this was the most frequently mentioned experience of loneliness. Words that have been used to describe this type of pain include, hurt, sorrow, ache, sadness, depression, torn up, bleeding, and broken. Clearly the pain is one in which the lonely individual feels damaged, as though someone their spirit was crushed. It hurts to feel lonely and it hurts even more because we don't have anyone to share it with.

(2) **Feeling lost, having no sense of direction:** Lonely individuals report feeling of being lost, confused and not knowing where they are going, it's because there is no one out there to give support to point out their mistakes, to maintain their sense of identity, and to praise them for doing good job. So, lonely individuals encircled in their own delusions and thinking accordingly with out considering others.

(3) **A Feeling of nothingness:** Another frequent feeling is that of nothingness. It has also been described as a void, a black hole, an abyss, hollow, and empty space. Basically there is a feeling that something is missing. When we break up with someone we didn't want to break up with, or we are missing someone we love dearly; we feel a hole in our heart. When we are hungry for food, our stomach growls, we get an empty feeling in the pits of our stomachs, we can't stop thinking about food, and sometimes it even hurts. In the same way, loneliness is a hunger for others, a psychological need that must be satisfied. Aristotle called us social animals, in that we need other people. When people are isolated, abandoned on a deserted island for example, they make pseudo friends in the case of Robinson Crusoe he made friends of the animals there, and in the case of Castaway, he made a friend out of a football. The need for people is a very real need, and therefore when it is not satisfied, the feelings of hunger, of nothingness, of void is bound to occur as well.

(4) **A Persistent feeling:** For someone individuals, loneliness has been an affliction that has been going on for a very long time – one of the poets described it as going on for years. These individuals experienced trait loneliness. There are several reasons that someone would experience

loneliness over such an extended period of time. The first reason is that the person is in an inescapable situation that is by its very natural isolating circumstances. For example, a person whose job requires constant moving from place to place, will probably not find the time to make secure friendships and may experience loneliness. A second reason is that a person grew up in a rejecting and/or abuse environment.

(5) **Loneliness can be overwhelming:** In some cases, loneliness can be overwhelming, so overwhelming infact that lonely individuals feel like they are about to burst! There is a feeling of despair, not knowing how much more of this painful loneliness one can take, feeling as if one is going to break apart at any minute. It's like blowing up a balloon past its normal capacity. Lonely individuals may feel this way because very often one is experiencing a wide variety of emotions and experiences, and yet there is no one to talk to, no one to share it with.

(6) **Having no control over loneliness:** Some parts describe being unable to take control over their loneliness. Sometimes loneliness is objectified into a person, and loneliness takes on a personality all of its own. In this way it has its own whims and fancies, it behaves in whatever way it feels like. Other poets describe it as a jail, a prison cell, an inescapable reality, anywhere they turn there is loneliness staring them in the face. In these ways loneliness has grown greater than the individual. Individuals who feel this way are probably not facing something important in their lives, they are avoiding dealing with something. Several authors have suggested that this type of loneliness has its roots in childhood; with feelings of unfulfilled love and attachment, experiences so deep inside the person now, that the demon that manifests itself as loneliness seems to have a life and personality all of its own.

(7) **Feeling no emotions, feeling numb:** Cold, frozen, void of true emotions. These are some of descriptions that have been associated with feelings of loneliness as well. It is almost as if we have shutdown our emotions center. As already discussed the fact that loneliness can be very painful, overwhelming, resulting from rejection or abuse. At some point in time, we may decide not to feel anymore, we may become so overburdened with all the pain, the hurt, the

sorrow, the loss of control that we shut our emotion center down. We don't want to feel anymore. In these instances, lonely individuals put themselves in cold, frozen places where they don't have to feel anything.

(8) **Feeling other emotions:** Several other emotions like feelings of being scared and afraid, or angry or hatred. For some people who have known what it is like to have close friends and family around, being isolated and alone can be very frightening and scary. There is a desire for comfort and security. Children, for example, sometimes use their parents as a supportive base, and when strangers or danger approaches they run back to their parents for security. In much the same way this continues throughout a person's life. When that security is gone, and loneliness appears, it can also be a frightening time as well. For other people through, there is a lot of bitterness and resentment. Usually it is against the people whom lonely individuals perceive have hurt them in the past or present. It could be a ex-relationship, or people in general or the world, has hurt them and they are angry. And so, in addition their feelings of loneliness they also respond with feelings of anger.

TYPES OF LONELINESS

There are basically two types of loneliness as given below:

(1) State loneliness

(2) Trait loneliness

State loneliness is temporary and depends on the situation that the person is involved in. For example, a person might go to a new place and not be very familiar with it or a person might take up new job. In such a situation, an individual might initially feel lonely, but build good relationships later.

This loneliness is generated more by the environment than the person. So they probably will experience loneliness only when it's a long rainy day and they have nothing to do, or go on vacation and missing their friends at home or something like it. The loneliness is generated circumstances they are in, and usually doesn't last very long (a day, a week).

Trait loneliness is more stable and enduring. Person experiences loneliness all the time, as an in escapable part of their existence. The inherent traits of the person

become a cause for his/her loneliness, which needless to say is miserable condition. The situation does not make any difference to a person with trait loneliness. He/she will feel lonely in a familiar as well as an unfamiliar situation.

This is type of loneliness that follows them everywhere. The loneliness is generated from the person, although particular circumstances might aggravate his experiences of loneliness... So regardless of the situation or circumstance, when they think about it, they are still lonely.

It is possible that an individual who experiences state loneliness might develop trait loneliness. This may happen, if a person does not stay or live at one place for a long period of time. For instance, a young boy or girl, due to various reasons, might have to study in many different schools. The same may happen to a person who has transferable job or has work that requires him/her to travel a lot. Such an individual might not be able to build intimate relationships, for obvious reasons. This happening regularly will habituate him/her to feel lonely. Thus, state loneliness may develop into trait loneliness.

Apart from the above mentioned causes of loneliness, there are other factors that contribute in the development of Loneliness. Loneliness doesn't develop overnight. It can be the result of a lifetime of influences that shape our personality. Or it can evolve after a major transition or trauma. Often we are unaware of the subtle forces that can slowly lead us into self-imposed isolation.

Some people tend to be loners because of circumstances in their childhood development. For example, growing up with an unaffectionate or overly critical parent may make one shy away from intimacy with others. Some people simply never learn to communicate well or get along with their peers. Others have excessively aggressive or demanding personalities; that make people withdraw out of intimidation. Conversely, people with low self-esteem often withdraw from social situations they believe will lead to rejection. Loneliness can become lifestyle for the person who struggles with poorly developed interpersonal skills.

There are also many social factors that contribute to loneliness. We live in age in which modern technology has made it easier to do things without other people and without leaving our homes. Television is the chief culprit that robs us of time with relatives and neighbours. For some, especially the elderly, the likelihood of becoming

the victim of a crime keeps them from venturing out of their homes. Also, because our society is more mobile than in past, families may relocate several times for career advancement or other reasons, which tends to discourage the development of deep friendships.

Loneliness can result from "situational factors", circumstances in life that increase the possibility of isolation. People who are unmarried, divorced or widowed are more likely to encounter loneliness simply because they are more likely to be alone. However, loneliness can occur when a marriage relationship doesn't produce the closeness we expect. The student separated from home, the leader who must remain aloof from his subordinates, the individual with a disability or disease _ all face a greater chance of loneliness due to a situation in their lives.

Often loneliness brought on by developmental, social or situational factors leads to problems that only worsen loneliness. Alcoholism, drug abuse, family breakdown and other social ills are frequently rooted in loneliness and usually lead to greater alienation from meaningful human contact. The proliferation of gangs, religious cults and other deviant social groups can be attributed largely to people's need to belong somewhere and their failure to find acceptance in a traditional setting.

A large number of cross-sectional studies have been conducted to determine the correlates of loneliness. Most of the studies show a strong association with old-age. (Holmen K, Ericsson K, Andersson L., Winblad B. 1992; Holmen K. 1994; Vaarama M, Hakkarainen A, Laaksonen S.1999; Barreta D, Dantzler D, Kayson W.1995; Fees BS, Martin P, Poon LW. 1999; Tijhuis MA, De Jong- Gierveld J, Feskens EJ, 1999). Life- changes and losses tend to concentrate in old age: retiring from work and its social network and the losses of intimate relationships. Spouses, friends and relatives die when a person reaches a very old age. Frequent association of loneliness and agemay also derive from other factors, such as gender, health and functioning, which are independently associated with both age and loneliness (Victor C, Scambler S, Bond J, Bowling A. 2000). On the other hand, the content, value and meaning of the feeling of loneliness may change with aging (Andersson L. 1998). Some researchers have suggested that the feeling of loneliness is more common among people over 75 years old than among younger adults, but that the prevalence of loneliness levels off after the age of 90 years (Anderson L. 1998)

The association of gender, marital status or childlessness with loneliness has been examined intensively. According to some studies, males are more often lonely than females (Andersson L, Stevens N. 1993; Chang SH Yang MS. 1999), but other studies have reported results to the contrary (Holmen K, Ericsson K, Andersson L., Winblad B. 1992; Kivett VR. 1979). Females might have a larger social network than males. On the other hand, sometimes males are not as willing as females to recognize and relate their feelings of loneliness (Andersson L. 1998; Victor C, Scambler S, Bond J, Bowling A. 2000). Male loneliness has been linked to divorce, widowhood, bachelorhood, childlessness, lack of friends, poor health, and physical limitations and to a poor economic situation (Mullins LC, Elston CH, Gutkowski SM. 1996; Zhang Z, Hayward MD. 2001). According to the study of Dysktra and de Jong Gierveld (1999), single males are lonely more often than single females, but there is no difference in the prevalence of loneliness among single and recently married males. In another study by Koropeckyj-Cox (1998), widows and widowers were more often lonely than those who had never been married, even though the former had children.

Widowhood and the loss of a close friend are clear determinants for loneliness (Tijhuis MA, De Jong-Gierveld J, Feskins EJ, Kromhout D. 1999; Kivett VR. 1979; Berg S, Mellestrom D, Persson G, Svanborg A.1981; Henderson AS, Scott R, Kay DW. 1986; Essex MJ, Nam S. 1987; Hector-Taylor L, Adams P. 1996; Holmen K, Ericsson K, Winblad B. 1999; Van Baarsen B, Smith JH, Snijders TAB, Knipscheer KPM. 1999; Costello J, Kendrik K. 2000; McInnis GJ. 2000; Van Baarsen B. 2000). Widowhood may lead to a collapse of a social network if the deceasedpartner had maintained the network. On the other hand, sometimes ending a stressful human relationship or marriage can also be relief and may release a person from social isolation and loneliness (Essex MJ, Nam S. 1987; Hansson RO, Jones WH, Carpenter BN, Remondet JH. 1986). Loneliness also affects the spouses and caregivers of dementia patients, among whom loneliness is associated with depression (Beeson R, Horton-Deutsch S, Farran C, Neundorfer M.2000).

There are conflicting results as to whether childlessness has an impact on the experiences of loneliness (Koropeckyj-Cox 1998; Mullins LC, Johnson DP, Andersson L. 1987). Some studies have shown that childlessness is associated with loneliness (Mullins LC, Elston CH, Gutkowski SM.1996; Linnemann MA, Leene GJ.1990) and some have not (Zhang Z, Hayward MD.2001; Koropeckyj-Cox 1998). It

has been suggested that childless actively learned to create human relationships during their lifespan. Childless adults do not necessarily expect their friends or relatives to maintain as frequent contact as parents expect from their children (Mullins JC, Dugan E. 1990).

In a Finnish Study, older female residents (n =120) residing in permanent institutional care felt loneliness to be associated with dissatisfying human relationships in their institutions. These women felt they were not accepted in their institution, and they had to call and wait for help (Nores T. 1993). According to another researcher, long term care residents may experience loneliness in several ways. They may experience physical loneliness, which means having to give up normal independent life and all that is familiar and instead experience the unfamiliar environment of the institution. They may also experience social loneliness, with the absence of close and familiar people and long periods spent alone and in activity. Emotional loneliness among institutionalized redidents was described as feeling unwell, with a sense of yearning and a belief that life is totally meaningless (Parkkila M, Valimaki M, Routasalo P. 2001).

Lack of a social network and having few social contacts (Chang SH, Yang MS.1999; Mullins IC, Dugan E. 1990) are all clearly associated with loneliness. Elderly people who have limited social networks do not receive enough support and emotional satisfaction (Bondevik EK, Knafl KA. 2003). Losses thinning the network, a person's incapability or unwillingness to create new social contacts and poor self-awareness and insecurity may all lead to social isolation (Ruth J-E, Oberg P, Tornstam L. 1988). In addition, attitudes towards life and towards human relationships such as hopelessness (Beck C, Schulz C, Walton CG, Walls R. 1990), inactivity (Vaarama M, Hakkarainen A, Laaksonen S. 1999) and lack of future expectations (Ruth J_E, Oberg P, Tornstam L. 1988) are associated with loneliness.

CONSEQUENCES OF LONELINESS

The Prognostic significance of social isolation is well known: Social isolation predicts **mortality** (Sugisawa H, Liang J, Liu X. 1994;Berkman LF, Syme SL. 1979; Jylha M, Aros. 1989; Olsen RB, Olsen J, Gunnar-Svensson F, Waldstrom B. 1991), **impairment of physical functioning** (Bisschop MI, Kriegsman DM, Van Tillburg TG et al. 2003) and **dementia** (Walker EA, Katon WJ, Russo J et al. 2000). Although

the concepts of social isolation and loneliness are close, it has been suggested that the subjective feelings of loneliness have also an independent impact on prognosis. Loneliness has also predicted **impaired survival** (Tilvis RS, Pitkala KH, Jolkkonen J, Strandberg TE. 2000; Penninx BWJH, Van Tilburg T, Krigsman DMW et al. 1997; Herlitz J, Wiklund I, Caidahl K et al. 1998), an **increased use of health services** (Ellaway A, Wood S, Macintyre S. 1999; Geller J, Janson P, McGovern E, Valdini A.1999, an **increased risk of nursing home admission** (Tilvis RS, Pitkala KH, Jolkkonen J, Strandberg TE. 2000; Russell DW, Cutrona CE, de la Mora A, Wallace RB. 1997). This seems to lead to an increased risk of dementia (Tilvis RS, Pitkala KH, Jolkkonen J, Strandberg TE. 2000), and to the poorer outcomes of medical treatment (Walker Ea, Katon WJ, Russo J et al. 2000). Several studies have demonstrated a correlation between increased loneliness and a variety of predictor variables, e.g:- low vision (Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1994; Barron CR, Foxall MJ, Dollen KV, Shull KA, Jones PA.1992; Barron CR, Foxall MJ, Dollen KV, Shull KA, Jones PA. 1994), **reduced hearing** (Chen H-L. 1994; Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B.1992), **low income** (Paplau LA, Perlman D.1992), **low education** (Paplau LA, Perlman D. 1992) and **loss of a spouse** (Thorsen K. 1990; Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1992; Tornstam L. 1988; Jones AA, Victor CR, Vetter NJ. 1985). A Connection has also been demonstrated between a low activity of daily life (ADL) score and loneliness (Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B.1992). However, the picture is not entirely unequivocal, since a survey from Bergen arrived at the opposite conclusion: there was increased loneliness with higher ADL independence (Bondevik M. 1997). A correlation has also been established between the cognitive functional level measured by Mini Mental State Examination (MMSE) and loneliness (Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1992; Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1993).

An extensive study in Stockholm of 1725 individuals over 80 years old concluded that loneliness is related to age, sex, marital status, social contacts, friends, health and cognitive function. The main predictors for loneliness were dissatisfaction with social contacts and habitation, followed by low self-perceived health and impaired cognitive function (Holmen K, Andersson L, Ericsson K, Rydberg L,

Winblad B. 1992). The correlation between self-percieved health and loneliness was also shown in the Albertine project (Lindgren AM, Svardsudd K, Tibblin G. 1994).

Loneliness may lead to serious health-related consequences. In the Gothenburg study Svanborg (1977) showed that loneliness results in more medical consultations (Svanborg A. 1977). Loneliness is one of the three main factors leading to depression (Green BH, Copeland JR, Dewey ME, Sharnra V, Saunders PA, Davidson IA, Sullivan C, McWilliam C. 1992)., and an important cause of suicide and suicide attempts.

A study sponsored by United Nations, Economic Commission for Europe, Institute for Older Persons and Social Services and United Nations Population Fund found causes of loneliness among elderly people :

Loneliness may be caused by diverse reasons which depend on each individual, there are three personal contexts which can trigger off the feeling of loneliness among elderly people:

1. Deteriorated family relations
2. Social isolation
3. Diminished participation in pleasure giving activities

Elderly people are in contact with other people quite often. Forty-five percent hold social relations on a daily basis, 26% do so between one and six times a week, 14% once a week, and only 15% claim not to hold any weekly social relations. Although the frequency of social relations does not depend on the degree of loneliness, the latter does affect the quality of these social relations. Seventy-eight percent of the elderly people who feel lonely are satisfied with their social relations. This figure, though quite high, is lower than the figure for those who do not experience loneliness 98%). The satisfaction that is obtained depends on the closeness of the kinship relation and the nearness, geographically speaking, of the people with whom they relate. Relations with next of kin are more agreeable than relations with friends or acquaintances, though these two are also satisfactory. Within kinship relations the most satisfying ones are those held with grand children or children, particularly if they live in the same town.

The feeling of loneliness can also appear when no pleasurable activities are carried out, since these activities prevent the appearance of negative thoughts. Those people who claim not to feel lonely are more active in their leisure time. They carry out a great variety of activities. They go for walks in the park (73%), they red (54%), they go to pubs and coffee-shops (35%), or they attend a club for retired people (26%), all these figures being higher than those for people who experience loneliness and also perform these activities (64%, 46%, 26% and 18% respectively).

Three events that can result in loneliness –

1. Children leaving the home
2. Widowhood
3. Retirement

With the passing of time and mainly in old age, people go through very hard experiences which bring about a break with their previous way of life. These experiences may have serious emotional consequences for those who undergo them (e.g., depression, loneliness, loss of self-esteem, etc.). The first significant event that elderly people have to face is the children leaving the parental home to start an independent life. This event can lead to depression and loneliness in elderly parents if they do not keep up fluent relations with their children (Empty-nest syndrome). Moreover, parents expect their children to assist them in times of illness or dependence. Not complying with this duty which many elderly people consider essential – can deteriorate the parent child relationship and give rise to feelings of loneliness and helplessness.

The feelings that appear when children leave the parental home can be overcome and even prevented if the married couple is a source of companionship where the spouses can share interests and love. Because of this, the death of one of the spouses is the most traumatic event elderly people go through. When the couple has a close relationship, the emotional impact on the death of one of the spouses will be all the greater, and the feelings of loneliness and misery will not be alleviated by any other person.

The other important event in the lives of elderly people is their withdrawal from the labour market. After retirement, people have more free time and, more often than not, they do not know what to spent it on. Moreover, the lower income that is

part of the new situation restricts the possibilities of enjoying the moments of leisure. Another of the effects of retirement might be social isolation. People in certain professions foster social relations among colleagues, but they give them up when they stop working. These circumstances contribute to the fact that, on retirement, many elderly people busy themselves by doing activities only at home and as a result lose all contact with friends.

DETERMINANTS OF LONELINESS

Age, Gender, Culture

Contrary to popular stereotypes, it is not the elderly who suffers the most from loneliness. Numerous studies have identified the young adolescents and young adults – as the loneliest age groups (Peplau et al., 1982). As people mature and move beyond the young adult years, their loneliness tends to decrease until relatively late in life, when factors such as poor health and death of loved ones increase social isolation (Green et al., 2000). One reason why adolescents and young adults may be lonelier than older individuals is that young people face many more social transitions, such as falling in and out of love for the first time, leaving family and friends, and training and searching for a full time job – all of which can cause loneliness (Oswald & Clark, 2003). Another reason for this decrease in loneliness with age is that as we mature, we often settle into long-term romantic relationships and marriages, where the accompanying emotional bonds contribute to overall mental health (Rusell, 1982).

There are clear age differences in loneliness, but gender differences are not as clear cut. Some studies have found a slight tendency for women to report greater loneliness than men, yet other studies fail to find any differences at all (Archibald et al., 1995; Brage et al., 1993). Despite any firm evidence for gender differences in the degree of loneliness, there does appear to be evidence that men and women feel lonely for different reasons. Men tend to feel lonely when deprived of group interaction; women are more likely to feel lonely to when they lack of one-to-one emotional sharing (Stokes & Levin, 1986).

Regarding cultural differences in loneliness, a recent survey of people living in Canada, Turkey and Argentina conducted by Rokach and Bacanli (2001) found that the individualists Canadians not only experienced higher levels of loneliness than the collectivists turks and Argentinians, they also had different perceptions of what

caused their loneliness. Canadians were much more likely to explain their loneliness as being caused by personal inadequacies than the Argentinians and Turks. These cultural differences in loneliness are most likely due to expectations that individualists and collectivists have about social relationships and the degree of help they receive in establishing socialites. While individualists are socialized to develop loosely knit relationships, and to do so by relying on their own social skills and initiative, collectivists are taught to develop tightly knit relationships within their existing group, and to do so with the assistance and supervision of ingroup members (Miller & Prentice, 1994; Tower et al., 1997). In a very real sense, the social world constructed by individualists is more likely to create loneliness in its members than the social world created by collectivists. Further, when loneliness is experienced, individuals are more likely than collectivists to explain it in terms of internal, stable factors ("I'm lonely because I'm personally inadequate"). This type of self-blaming crates a mind-set that discourages lonely people from seeking out others. Overall, Rokach and Bacanli's findings, suggest that the social world created in an individualists culture is not only more likely to cause loneliness, it is also more likely to perpetuate it.

Social Skills Deficits

Similar to the negative consequences of social anxiousness, chronically lonely people often think and behave in ways that reduce their likelihood of establishing new, rewarding relationships. Studies conducted with college students illustrate some of these self-defeating patterns of behaviour. Typically, in these investigations, students who are strangers to one another are asked to briefly interact in either pairs or groups, after which they rate themselves and their partners on such interpersonal dimensions as friendliness, honesty, and openness. Compared with nonlinely individuals, lonely college students rate themselves negatively following such laboratory interactions. They perceive themselves as having been less friendly, less honest and open, and less warm (Christensen & Kashy, 1998; Jones et al., 1983). They also expect those who interact with them to perceive them in this negative manner. This expectation of failure in social interaction appears all the more hopeless to the chronically lonely because they believe that improving their social life is beyond their control (Duck et al., 1994).

If chronically lonely people were merely misperceiving their effect on others, we might expect that other people's positive feedback concerning their social competence would break down their misperceptions. The problem, however is that the chronically lonely tend to lack social skills and, as a result, receive little positive reinforcement from others concerning their interaction style. Indeed, they are generally disliked or ignored by others, who see them as week, unattractive, and insincere (Rotenberg et al., 1997).

Chronically lonely persons exhibit social skills deficit in their daily interactions. When conversing with another, the chronically lonely spend more time talking about themselves and take less interest in what their partner has to say than do nonlonely people (Jones et al., 1982). Consistent with the interaction style of those with low self-esteem, they also tend to perceive others in a negative light (Rotenberg & Kmill, 1992). When meeting such a person, new acquaintances often come away with negative impressions (Jones et al., 1983). Confronted with the negative social judgements accompanying this sort of inept social style, lonely individuals often immerse themselves in their occupations, withdraw into wish-fulfilling fantasies, or engage in self-destructive activities such as alcohol and drug abuse. Not surprisingly, lonely people often use the television, computer, and radio as substitutes for interpersonal relationships. Unfortunately, the content of a good deal of mass media programming focuses on failed relationships and sadness, which actually can deepen one's sense of social isolation (Davis & Kraus, 1989).

TECHNIQUES TO OVERCOME LONELINESS

Unless a major effort is made to improve interpersonal interactions, loneliness will not magically go away. Lonely individuals tend to retreat into wish-fulfilling fantasies, become absorbed in their occupations, or turn to alcohol and drugs (Revenson, 1981). Some rely on music as a substitute for interpersonal relationships, but songs of separation, heartache and sadness actually agravate feelings of loneliness (Davis & Kraus, 1989). Because these coping strategies only make things worse so two successful techniques, often used together, cognitive therapy and social skill training.

The cognitions of lonely and nonlonely people are found to differ. The self-schema of lonely individual brings about selective attention to negative information

involving himself or herself, thus confirming and strengthening an already negative self-concept (Frankel & Frentice-Dunn, 1990). Cognitive therapy is designed to alter such cognitions, especially with respect to social situations. If, for example, a man perceives himself as dull and boring, a therapist may be able to convince him that this self perception is incorrect or to help him give up his false belief that only witty and exciting people can make friends. If a woman reacts to social situations as stressful because she feels others are always evaluating her (Asendorpf, 1989), she can learn that she really isn't the center of everyone else's attention.

Such changes in cognitions need to be accompanied by behavioural changes. Those who are lonely not only lack appropriate social skills, they also are anxious about not possessing these skills (Solano & Koester, 1989). One form of social skills training is to expose a lonely individual to interpersonally successful role models on videotape. The person can also practice social skills in a non-threatening situation and view the results on tape. Specific interactions (such as initiating a conversation) can be prescribed and rehearsed. Sometimes the needed skills are very specific – how to speak easily on the telephone, give compliments, or improve one's physical appearance.

The effects of these efforts can be remarkable, even in a short period of time (Young, 1982). Once a lonely person thinks about social situations in a new way, learns how best to interact with others, and changes his or her interpersonal style, the resulting interpersonal successes can eliminate loneliness.

Therapy is a common and affective way of treating loneliness, and is often successful. Short term therapy, the most common form for lonely or depressed patients, typically occurs over a period of 10 to 20 weeks. During therapy, emphasis is put on understanding the cause of the problem, reversing the negative thoughts, feelings, and attitudes resulting from the problem, and exploring ways to cure the patient. Some doctors also recommend group therapy as a means to connect with other sufferers and establish a support system.

Doctors also frequently prescribe anti-depressants to patients as a standalone treatment or in conjunction with therapy. It usually takes a few tries before a patient finds the correct anti-depressant medication. Some patients may also develop a resistance to a certain type of medication and need to switch periodically.

Alternative approaches to treating depression are suggested by many doctors. These treatments may include exercise, dieting, hynosis, electro-shock therapy, acupuncture, herbs and many others. Many patients find that participating in these activities fully or partially alleviate symptoms related to depression.

Another treatment for both loneliness and depression is pet therapy, animal assisted therapy, as it is more formally known. Some studies and surveys, as well as anecdotal evidence, provided by volunteer and community organizations, indicate that the presence of animal companions dogs, cats, and even rabbits or guinea pigs can ease feelings of depression and loneliness among some sufferers. According to the centers for Disease Control, there are a number of health benefits associated with pet ownership. In addition to easing feelings of loneliness (because of the increased opportunities for socializing with other pet owners, in addition to the companionship the animal provides), having a pet is associated with lowered blood pressure and decreased levels of cholesterol and triglycerides.

STEPS FOR OVERCOMING LONELINESS

Apart from the techniques discussed above the following steps will also help the people break free from thinking, emotions and behaviours that may be at the root of their loneliness.

Admit the Problem: Only after people acknowledge that they are lonely can take the steps necessary to escape from their isolation.

Accept What Cannot be Changed: The death of a spouse, a relocation away from old friends, and other unalterable circumstances must be faced squarely. God can use transitions in our lives to open doors to new experiences, but we must be willing to let go of the past and move on.

Alter What Can Be Changed: Many of the causes of loneliness can be overcome by practicing :

(a) Work on developing self-esteem by stopping destructive self-talk, such as telling yourself that you are unlikable. There are many good books on the subjects or rational thinking and misbelief therapy that can help.

(b) Practice looking from God's perspective. Study the scriptures and mediate on verses that depict God's view of His believers.

(c) Make it a point to get out of the house at least once a week. Participate in community functions, take a class, etc.

(d) Get involved in a cause. There are many groups looking for faithful volunteers who want to make a difference. Of course, working for a ministry or charity is also a great way to meet people.

Develop New Habits that Build Up Inner Self: As person become a stronger, more self-assured he will find it easier to make new friends and encounter new situations. Try some of these strategies for self-improvement.

(a) Mediate on God's word for relaxation and to ease the effects of stress on their life.

(b) Establish a schedule for a day, weakened or a week. Loneliness often seems more intense when we have nothing to do. Organize their time and be sure to include some outside activities.

(c) Start exercise regularly. Take walks around their neighbourhood, a local park or a shopping mall. They'll feel better physically and emotionally.

Make the most out of your time alone. Aloneness (as opposed to loneliness) can be a very positive experience. Aloneness, or solitude, gives us a chance to reflect on our lives, to mediate on God's will for us and to find healing for the wounds inflicted by the world. Many experts feel that we spend too little time alone and that we would all be better off by planning regular times of solitude in our lives.

Make an Effort to Make New Friends: Often all that is required to escape loneliness is the determination to seek out a new friend. Overcoming shyness and the fear of rejection are usually the biggest obstacles to initiating a friendship. Keep the following in mind when try to establish new relationships:

(a) Look for someone with whom they can share a common interest.

(b) Take the initiative and give the person a call chances are that person may be looking for a friend as well.

(c) Build a friendship slowly. Don't overwhelm a new acquaintance with problems and opinions. With time the openness to express feeling will develop. Give

compliments and be thoughtful. Refrain from giving unsolicited advice. Be a good listener.

Consider Buying a Pet: Pets can be a wonderful source of companionship. Don't overlook the possibilities. Pets offer uncomplicated companionship and unquestioning affection. They can even become the catalyst for friendships with other pet owners.

COPING STRATEGIES

Our reaction to loneliness is called a coping strategy. Research on loneliness done by Rubenstein and Shaver shows that there are four main categories of coping strategies. These are as follows:

Active Solitude

The first type of coping is called active solitude. This means that when we feel lonely we have a tendency to engage ourself in active behaviours, like writing or reading, etc. These kinds of behaviours are generally believed that people who engage in active solitude tend to be individuals who suffer more from state loneliness than trait loneliness. That means we are probably lonely because of some situation we presently find ourself in (like moving to a new area) and if the situation were to change we would probably feel a lot better. Our friends probably won't describe us as a very lonely person. Therefore active solitude is a good way in trying to deal with loneliness, especially if it is a situation we can't escape.

Spending Money

The second type of coping is called spending money. In general, it is thought that spending money can have some beneficial effects, because it gets us out of the house (assuming that we shop offline, in malls and shops) and meeting new people. But if we are spending money doesn't cause us to get out the house and meet new people, then it probably isn't such of a good thing. The researchers studying this type of coping were a bit ambivalent as to whether this is a good or bad coping strategy. In any case, if we are speding money we don't have for things that we don't need, then this type of reaction to loneliness can prove to be extremely unhealthy. We should consider buying things that will cause us to be social with other people. The important thing is, when we feel lonely, get up, get out of the house, got out to the malls, see what they have, and just look around without spending too much. Perhaps we can

leave our credit cards and money at home, so that we will be forced not to spend anything. And carry a friend and see the sites together.

Social Contact

This third type of coping to loneliness is called social contact. In general, it entails trying to call a friend, going to visit someone or trying to establish some kind of social contact when he has feelings of loneliness. The researchers thought that social contact may be a good way of dealing with loneliness. In general though, he should not be burdening his friends with constant calls for social contact. But if he has friends to talk to, and yet he still feel lonely. May be because the relationships he has aren't as fulfilling as he would like them to be. May be he needs to go out there and make some new friends who can satisfy the need for a deeper relationship. May be he should take one of his present relationships to a deeper level. Something to think about.

Sad Passivity

Out of all the types of coping strategies to loneliness, this is the most looked down upon. But don't despair. Sad passivity means that we are involving ourself in types of behaviours that amplify our loneliness instead of relieving it. These behaviour include such things as watching TV, sleeping, eating, taking tranquilizers (or alcohol, etc.) sitting and thinking and doing nothing. By engaging in these types of behaviours it only makes our situation worse, and the loneliness only pains us more sometimes. But we probably feel powerless to do anything to change our situation. We have to make a conscious decision to stop this sad passivity and move onto something more positive. Take one step at a time, find a new hobby go out and join a new club, pick up exercising, find something useful to do with our time, something that will make us a better. Find someone to talk to about loneliness. It's okay to feel lonely, but it's not okay to keep feeling lonely all the time. It's time to move up and move on!

In previous section we have described some researches that suggested several ways in which individuals cope with loneliness. There is some overlap between what was said there and what will be said here. However, these give more specific examples and in some cases unique examples of how individuals cope with loneliness.

1. The Desire for Someone: The most frequent way that people coped with feelings of loneliness, as mentioned in the poems, was by imagining having someone there. In some cases it was romanticized, having the knight in shining armor coming to rescue them from their loneliness, or having the perfect lover or friend. In other cases though, it was just something more general, just to have someone there to share our thoughts and feelings with, having someone to care. Yet in other cases, the object of affection was very specific, and in such cases the poet was imagining that particular object of affection there next to them, picturing their face, their smell or their presence. All cases required that dreaming of that special someone, fantasizing in an attempt to fill the void of loneliness.

2. Crying: The second most frequent activity reported was crying. Pain is usually accompanied by tears, therefore loneliness would also be accompanied by tears.

3. Hiding Feelings: Some lonely individuals cope with loneliness through hiding their feelings. In some cases it seemed as if the revelation of their feelings would result in ridicule or rejection. In other cases it seemed as if it were culturally inappropriate to reveal any sign of weakness like loneliness. Poets described being an actor or a "professional faker", wearing different masks so that people will not know what is going on underneath. It was also often described their experiences as a secret, like their "secret loneliness" or their "secret tears".

4. Inactivity: Loneliness is also associated with periods of inactivity, such as lying in bed, sitting and thinking, curled up in a ball, etc. It is felt that during the periods of inactivity, lonely individuals are deeply within their minds, either fantasizing about their perfect companion, or fantasizing about some other obsession, or trying to make sense of their loneliness. Lonely individuals feel that they are lost or confused, having no direction or purpose. Very often in the poems, there would be the question of why me, why do I experience loneliness, what have I done to have this curse laid upon me. It may be that lonely individuals do spend quite a bit of time trying to make sense of their reality, trying to come to grips with this thing called loneliness. And doing this requires these periods of inactivity.

5. Withdrawal and Fantasizing: Loneliness has also been associated with day dreaming. When the outside reality is too painful to live in, we can construct quite comprehensive, interior fantasy worlds. In these fantasy worlds we construct heroes

and villains, we have our mythical stories to tell. We deny our outside reality, to live in an internal reality. Lonely individuals describe being able to pull into themselves, to escape from the present world, to go to a fantasy world, a dream world, an illusion. This interior world is our own litter safety net in which we exist. Sometimes it becomes manifest in the books we read or the games we play, things to help fuel our interior fantasy world. At the same time both highly creative and highly destructive.

6. Suicide Ideation: While some lonely individual may deal with the pain of loneliness by dividing into a fantasy world, other individuals may think that their only way out is through death. Death is the only escape to loneliness. It is described that there can be feelings of being out of control. That is, that loneliness seems to have a life of its own and can trap us into feeling lonely all the time, that is it is inescapable. It is no wonder therefore that some of us can feel like the only way we can overcome loneliness is to commit suicide. It is strongly recommend that anyone who is feeling this way, talk to someone especially a counsellor or professional who can help them deal with these emotions. Loneliness can be overcome, even if the person feel like he cannot escape it, there is away out, others have done it before him and he can too.

7. Religion: Religious coping is another way of dealing with loneliness. And it is not necessarily as elaborate as we think. In some instances, poets have made simple exclamations, like "oh god", and others have just being praying for help, praying for the perfect person to come into their life, praying for a miracle. Yet others have advocated a stronger use of religion claiming that for them it has help them to overcome their loneliness.

8. Sleep: The last notable coping strategy is sleeping. Some people use sleeping as a means of escaping their loneliness. Sometimes it was in the hopes that tomorrow or whenever they wake up again will be better that what went before.

EFFECTS OF LONELINESS

Chronic loneliness (as opposed to the normal loneliness everyone feels from time to time), is a serious, life-threatening condition. At least one study has empirically correlated it with an increased risk of cancer, especially for those who hide their loneliness from the outside world. It is associated with increased risk of stroke and cardiovascular disease. People who are socially isolated also report poor sleep quality and thus have diminished restorative processes. Loneliness is also linked

with depression, a risk factor for suicide. Emile Durkheim (2008) also described loneliness, specially the inability or unwillingness to live for others (i.e. for friendships or altruistic ideas) as the main reason for what he called 'egoistic' suicide.

Loneliness can play a part in alcoholism. In children, a lack of social connections is directly linked to several forms of antisocial and self-destructive behaviour, most notably hostile and delinquent behaviour. In both children and adults, loneliness often has a negative impact on learning and memory. Its effect on sleep patterns, as well as the above mentioned other effects can have a devasting effect on the ability to function in a everyday life. Some other effects may not be symptomatic for years. In 2005, results from the U.S. Framingham Heart study demonstrated that lonely men had raised levels of IL-6, a blood chemical linked to heart disease. A 2006 study conducted by the center for cognitive and Social Neuroscience at the University of Chicago found loneliness can add 30 points to a blood pressure reading for adults over the age of 50. Another remarkable finding, from a survey conducted by John Cacioppo, a psychologist at the University of Chicago, is that doctors say they provide better medical care to patients who have strong network of family and friends than they do to patients who are alone.

Cacioppo's (2008) book, Loneliness: Human Nature and the Need for Social Connection, outlines five distinct pathways through which social isolation contributes to increased illness and early death. He also offers an evolutionary rational for why the subjective sense of social isolation – loneliness – is so profoundly disruptive to human physiology that it impairs cognition and will power, alters DNA transcription in immune cells, and leads over time to high blood pressure.

Enforced loneliness (solitary confinement) has been a punishment method throughout history. It is often considered a form of torture.

LEISURE TIME ACTIVITIES

Another consideration that motivated the present author to undertake this proposed research is the existence of some evidence showing relationship between leisure time activities and general health of people.

Leisure time activity is one which we perform when we have free time i.e. leisure time activity is performed apart from those activities which are mandatory.

Evening and morning walk, watching T.V. or playing with grand children are the examples of leisure time activities. Elderly individuals who retire from their active services have no mandatory activities to perform. They may either remain idle or may engage themselves in leisure time activities. It has been shown that idle person or the person who have no activities to perform, develops obesity which in turn may have adverse effect on their general health. Elderly people, on the other hand, who keep them engaged in leisure time activities, are likely to prevent obesity and the occurrence of negative thoughts. Hence, such individuals are likely to experience less stress and hence are likely to have better general health as compared to those elderly individuals who do not perform any leisure time activity. One of the objective of the present study is to test this assumption.

Leisure or free time, is a period of time spent out of work and essential domestic activity. It is also the period of recreational and discretionary time before or after compulsory activities such as eating and sleeping, going to work or running a business, attending school and doing homework, household chores, and day-to-day stress. The distinction between leisure and compulsory activities is loosely applied, i.e. people sometimes do work oriented tasks for pleasure as well as for long term utility.

For an experience to qualify as leisure, it must meet three criteria: (1) The experience is a state of mind. (2) It must be entered into voluntarily. (3) It must be intrinsically motivating of its own merit (Neulinger, 1981).

HISTORY

In Europe for more than a century the history of the study of leisure has been dominated by issues of leisure participation and social stratification (e.g., Mommaas, Ven der Poel, Bramham & Henry, 1996; Mommaas, 1997). In this line of research, mostly driven by public planning interests, sociological perspectives have dominated the research agenda. Central issues focused on the non-participation of parts of the population and related patterns of social and cultural inequality.

From the beginning, direct explanations concentrating on the instrumental role of lack of time, bad working conditions, and lack of money and knowledge went along with indirect explanations that concentrated on the role of class-based status competition and the associated exclusionary practices (e.g. CBS, 1959). Historically,

preferred explanations shifted due to both the theoretical positions of researchers, the accumulated available knowledge, and changing social, economic, and political circumstances. Whatever the specific explanations used, agreement was found about the basic social and cultural structure informing both the leisure research and leisure policy agenda. As far as leisure was concerned, this structure was organized around dichotomies such as those between the refined and the vulgar, public and commercial, active and passive and the complex and the simple. This cultural hierarchy reflected and was maintained by a differentiative in the social structure based on an unequal distribution of levels of income and/or education. Those individuals high on income, and education differentiated themselves from those low on income and education by more refined, more complex, and more prestigious forms of leisure-participation especially found in public sector. Those people low on income and education had to resort to more simple forms of leisure mostly prevalent in the commercial sector. As a result, Dutch public leisure policy was aimed at stimulating the access to more legitimate forms of leisure either by subsidizing leisure facilities or by introducing alternative forms of legitimate leisure (e.g., culture and sports) in the national curriculum (Bramham, Henry, Mommaas and Ven der Poel, 1993).

In the 1970s the French sociologist Pierre Bourdien (1984) still pictured a French society in which a one dimensional cultural hierarchy dominated leisure persuits. Those people high on income and education were striving toward legitimate forms of leisure, while those low on income and education were making a virtue out of necessity' by celebrating popular forms of leisure. Today, however, many argue that this overall picture of relation between the social structure and the cultural composition of the leisure field has become more complex (e.g., Featherstone, 1991; Holt, 1997; Katz Gerro, 2002; Peteroson, 1992; Rojek, 1993; Urry, 1990; Wynne & O'Connor, 1995). This criticism cannot be reduced to a better and more detailed insight into the complexities of social and cultural reproduction only. Also responsible are changes in both overall social structure of western societies and the organization of the leisure field. Regarding the former, authors point at the rise of the middle class and the decline of the conventional working class both in size and in political and socio-cultural significance (e.g. Henry, 1995). At the same time, the leisure field has become more open with all kinds of national public cultural monopolies being sidetracked by different kinds of global cultural flows (e.g., media, tourism

migration). This change has introduced new cultural goods and leisure activities (Mommaas, van den Heuvel & Knulst, 2000). As a combined result, the leisure field has become more unstable, open, and difficult to "read". In terms of existing cultural hierarchies, the field has become polycentric. Leisure practices, as well as the ways in which fractions of population relate to these issues, have become more diverse.

The word leisure comes from the latin word licere, meaning "to be permitted" or "to be free", via old French leisir and first appeared in the early fourteenth century.

The notions of leisure or leisure time are thought to have emerged in Victorian Britain in the late nineteenth century, late in the Industrial Revolution. Early factories required workers to perform long shifts, often up to eighteenth hours per day, with only Sunday off work. By the 1870a, though, more efficient machinery and the emergence of trade unions resulted in decreases in working hours per day, and allowed industrialists to give their workers Saturday as well as Sundays off work.

Affordable and reliable transport in the form of railways allowed urban workers to travel on their day off, with the first package, holidays to seaside resorts appearing in the 1870s, a trend which spread to industrial nations in Europe and North America. As workers channeled their wages into leisure activities, the modern entertainment industry emerged in industrialized nations, catering to entertain workers on their days off. This Victorian concept – the weakened – heralded the beginning of leisure time as it is known today.

TYPES OF LEISURE ACTIVITIES

Active Leisure Activities: Active leisure activities involve the exertion of physical or mental energy. Low impact physical activities include walking and yoga, which expand little energy and have little contact or competition. High impact activities such as kick-boxing and soccer consume much energy and are competitive. Some active leisure activities involve almost no physical activity, but do require a substantial mental effort, such as playing chess or painting a picture. Active leisure and recreation overlap significantly.

Passive Leisure Activities: Passive leisure activities are those in which a person does not exert any significant physical or mental energy, such as going to cinema, watching television, or gambling on slot machines. Some leisure experts discourage these types

of leisure activity, on the ground that they do not provide the benefits offered by active leisure activities. For example, acting in a community drama (an active leisure activity) could build a person's skills or self-confidence. Nevertheless, passive leisure activities are a good way of relaxing for many people.

Apart from above some other type of leisure activities are:

(a) Hobbies: Among the most popular hobbies are photography, acting, music (playing and listening), gardening, knitting, drawing, collecting stamps, autographs and so forth, hiking, camping, fishing and bird watching.

(b) Reading: Although fewer individuals read now than in the past, plenty of people still love to curl up with a good book. Books allow readers to escape from daily cares, solve mysteries, travel to real or imaginary places, learn useful information, and find inspiration. Mysteries, romances, science fiction, historical novels, biographies, graphic novels, self-help books, magazine – the variety of available reading material is truly astounding.

(c) Surfing the Internet: A relatively new entry into the world of leisure, the Internet offers an amazing array of activities: e-mailing friends and relatives, meeting new people, visit chat rooms on topics of interest, playing multiuser games, listening to music, visiting world-class museums, and taking tours through ancient historic sites are just a few options.

(d) Travel: Many choose their destinations spontaneously, but others are more systematic in their travel plans. For example, some individuals want to travel to all the U.S. national parks or all the major civil war battlefields. Those who can afford it may travel to other countries – to get a taste of real French cooking or a first hand look at what remains of ancient Egyptian civilization.

(e) Games and Puzzles: Some individuals enjoy playing bridge for relaxation; others like to play board games such as Scrabble or chess. Computerized and video games are highly popular, especially with children and adolescents. For some, the day isn't complete without the daily crossword puzzle. Others like to assemble jigsaw puzzles.

(f) Sports: Many people like to play team sports such as bowling or softball, enjoying the benefits of both physical exercise and social interaction. Other enjoy

individual sports such as jogging, swimming, surfing, ice skating, or skiing. Kayaking is a popular option that can be done solo or with another.

(g) Volunteer Activities: Helping others appeal to individuals in almost all age groups. Moreover, a person can use his skills to help others in an incredibly diverse array of settings: homeless shelters, hospitals, schools, battered women's shelters, boy's and girls clubs, and sports teams. These are the best examples of volunteer activities.

EXAMPLES OF LEISURE ACTIVITIES

People who work indoors and spend most of their time sitting and doing sedentary office work can add physical activity to their lives by doing sports during their leisure time, such as playing a ball game, going camping, hiking or fishing. On the other hand, people whose job involves a lot of physical activity may prefer to spend their free time doing quiet, relaxing activities, such as reading books or magazines or watching T.V. some people find that collecting stamps, post cards, badges, model cars or ships, bottles, or antiques is a relaxing hobby.

Free time is organized in many schools and institutions. Schools offer many extracurricular activities including hobby groups, sport activities, and choirs. Other institutions such as retirement homes and hospitals also offer activities such as clubs and meetings for playing games.

Most people like socializing with friends for dinner or a drink after a hard day at work. For many young people, having a regular night out a week is a normal part of their free time, whether it is joining friends for a drink in a pub, dinning out in a restaurant, watching a film, playing video games or dancing the night away at a club.

Some people do leisure activities that have a long term goal. In some cases, people do a leisure activity that they hope to turn into a full time activity (e.g. volunteer paramedics who hope to eventually become professional paramedics). Many people also study part time in evening university or college courses, both for the love of learning, and to help their career prospects.

CULTURAL DIFFERENCES

Time for leisure varies from one society to the next, although anthropologists have found that hunter-gatherers tend to have significantly more leisure time than

people in more complex societies. As a result, band societies such as the Shoshone of the Great Basin cane across as extraordinary lazy to European colonialists (Farb, Peter, 1968).

Capitalist societies often view active leisure activities positively, because active leisure activities require the purchase of equipment and services, which stimulates the economy. Capitalist societies often accord greater status to members who have more wealth. One of the ways that wealthy people can choose to spend their money is by having additional leisure time.

Workaholics are those who work compulsively at the expense of other activities. They prefer to work rather than spend time socializing and engaging in other leisure activities. Many see this as a necessary sacrifice to attain high ranking corporate positions. Increasing attention, however, is being paid to the effects of such imbalance upon the worker and the family.

Throughout its early history, American society has been described as driven by the Protestant work ethnic, a cultural view that is said to be inspired by the Protestant preacher John Calvin.

LEISURE AND RECREATION AS RELATED TO HEALTH

Both leisure and recreation are crucial components of a balanced and healthy life style. Leisure time is a time when people can do what they want, separate from work and other commitments.

Recreation and leisure play an important role in social well-being by providing people with a sense of identity and personal people with a sense of identity and personal autonomy. Involvement in leisure time activities gives greater meaning to individual and community life and contributes to people's overall quality of life. Recreation can encourage personal growth, self-expression and increased learning opportunities, satisfying needs not met in people's non-leisure time.

For many people, participation in leisure and recreation improves physical and mental health. Recreation often involves a physical activity or sport. Increased physical activity can lead to fewer health problems and higher productivity at work, especially when combined with a balanced diet and healthy life style.

The benefits for mental health are equally important. Several studies have demonstrated links between regular physical activity and a reduction in the symptoms of mild or moderate depression, stress and anxiety. Passive leisure also has benefits for mental health by providing an outlet for the mind. It may provide physical rest, tension release and the daily routine opportunities to enjoy nature and participation in leisure and recreation activities can also have social benefits. It creates opportunities for socialization and contributes to social cohesion by allowing people to connect and network with others. It can also contribute to family bonding as families do things together in their leisure time.

Indicators

Three indicators are here and they are: satisfaction with leisure time, participation in sport and active leisure and participation in cultural and arts activities. Together, these indicators present a picture of how people feel about their leisure and also what they do in their leisure time. The first indicator is satisfaction with leisure time. This measures how people feel about both the quantity and quality of leisure time available to them. The second indicator measures people's participation in sport and active leisure. Moderate physical activity can improve a number of health outcomes, risk factors and disease.

The final indicator, participation in cultural and arts activities, measures people's involvement in cultural activities. Cultural activities contribute to individual growth, as well as provide opportunities for social cohesions and the passing on of cultural traditions.

Sex Differences

There are minimal differences between the sexes in reported satisfaction with leisure time. Eight percent of men and 79 per cent of women report they are "satisfied" or "very satisfied" with their leisure time.

Age Differences

While the majority of people are satisfied with their leisure time, those age 25-49 years are less satisfied overall (74 per cent). This age group tends to have larger work and family commitments than other groups, which may impinge on the time they have available for leisure. In comparison, those aged 15-24 years, and those aged

50-64 years are more likely to report being satisfied with their leisure time with total satisfaction levels of 78 per cent and 83 per cent respectively. Those aged 65 years and over report the highest levels of overall satisfaction with their leisure time (92 per cent).

In view of the foregoing discussion it is logical to assume that lonely persons who differ with respect to their beliefs about the causes of their loneliness may also differ with respect to their general health. More specifically it is assumed that the people who are high on loneliness scale are expected to show poorer general health as compared to those who are low on loneliness scale. One objective of the present study is to test this assumption since no such study has been undertaken till date.

Moreover as stated earlier elderly individuals who retire from their active services have no mandatory activities to perform. They may either remain idle or may engage themselves in leisure time activities. It has been shown that idle person or the person who have no activities to perform, develops obesity which in turn may have adverse effect on their general health. Elderly people, on the other hand, who keep them engaged in leisure time activities, are likely to prevent obesity and the occurrence of negative thoughts. Hence, such individuals are likely to experience less stress and hence are likely to have better general health as compared to those elderly individuals who do not perform any leisure activity. One of the objective of the present study is to test this assumption.

Chapter II

Review of Literature

REVIEW OF LITERATURE

As mentioned in the preceding chapter, the present study is undertaken to investigate the influence of loneliness, leisure time activities on general health. In this chapter, therefore, we will review those studies which are directly or indirectly relevant to the problem under investigation.

This chapter is divided into two sections. The section I reviews those relevant studies that demonstrate an impact of loneliness on general health. Section II is devoted to such studies which throw light on the relationship between leisure time activities and general health.

SECTION I

LONELINESS

As mentioned earlier this section of the chapter is devoted to the review of such studies which directly or indirectly demonstrate the impact of loneliness on general health.

Rotenberg (1997) conducted a study in which two experiments examined the differences between lonely and non lonely females in their judgments of the exchange of disclosures. 297 female undergraduates completed the revised UCLA loneliness scale. In Exp 1,120 Ss judged dyadic conversations in which 1 partner reciprocated or did not reciprocate the intimacy of disclosure; in Exp 2, 177 Ss judged conversation partners whose disclosures increasingly accelerated their partner's low intimate disclosures (no acceleration, low accelerating, and high accelerating). In both studies, lonely rather than non lonely Ss negatively evaluated the conversation partners (and their disclosure) when their own disclosure increased the intimacy of their partners' disclosure, and therefore accelerated it. The finding obtained in Exp 2 further indicated that lonely Ss negative evaluation increased as the acceleration of disclosure increased. Findings are consistent with J.P.Stokes' (1987) loneliness- disclosure model, indicating that lonely individuals' view unprompted intimate disclosure as *risky and undesirable.*

Keil (1998) explored the role of human- animal bonding in quality of life of older adults. More specifically, the relationships among pet attachment, loneliness, and stress were evaluated in 275. 52-91 yr old animal owners from 3 community programs for older adults in the mid western US. Measures included the Human-Animal Relationship Questionnaire for attachment and 2 Revised Philadelphia Geriatric Center Morale scale factors for loneliness and stress. Pearson correlations between attachment and loneliness and between attachment and stress indicated that as loneliness and stress increased, attachment increased. Visual interaction, dog ownership, stress, and the animal's appeal explained 31% of the variance of human-animal attachment. The correlation between loneliness and attachment was higher for participants without a human confident. These finding suggest that animals could become supplementary attachment figures for older people.

Kim (1997) examined whether loneliness predicts health perceptions, i.e., emotional and physical health in a sample of 174. 60-87 yr old Korean immigrants living in a metropolitan area served as subjects. Scores on the revised UCLA Loneliness Scale predicted scores on the Life Satisfaction Index-Z and perceived physical health in the older Koreans, but not scores on the symptom pattern scale. Older Koreans who reported being more lonely were less satisfied with their lives and perceived their health as being worse than those who scored as being less lonely in this study. These results based on data collected by telephone are consistent with previous studies which have reported a negative relationship between loneliness and life satisfaction and perceived health.

Wilkinson and Pierce (1997) explored the lived experience of aloneness for 8 older women (aged 55-75 yrs) currently being treated for depression. Transcriptions of 1-hr interviews with the Ss were reviewed via P. Colaizzi's (1978) method of data analysis. The analysis identified 2 major experiences of self for all Ss: aloneness in depression and aloneness in recovery. Five paired and somewhat dichotomous themes defined the essence of aloneness: (1) Vulnerability vs self-reliance, (2) fear vs hope, (3) helplessness vs. resourcefulness, (4) loss of self-control vs self-determination, and (5) identity confusion vs self-reflection. All Ss expressed profound feelings of moving into their experiences of depression and recovery. Implications for nursing were discussed.

Rokach (1998) examined the influence of cultural background on the perceived causes of loneliness. In the present study, 679 participants 318 men and 361 women; aged 16-89 yrs answered a 15-item loneliness questionnaire and represented 3 cultural backgrounds: North American, South Asian, and West Indian. Results showed significant differences in the perception of the antecedents of loneliness amongst the three cultural subgroups. Gender differences were also found across the cultures and within the North American and the west Indian populations.

Karen Kaasa (1998) studied the prevalence of loneliness in a group of elderly people over 80 years old and the sociodemographic, health-related and social predictors for experiencing loneliness. The information is obtained from a survey among 232 inhabitants in this age group in the municipality of Tons berg, its Northern District. The interview data are composed of the responses from 202 elderly people living in a house or apartment (non-institutionalized) to the question (do you generally feel lonely?) Results showed that 17% (CI 12.5-23.0) of the respondents answered yes. A significant correlation was demonstrated between a feeling of loneliness and low self-perceived health, low vision and poor hearing, low activity of daily life (ADL) function, loss of a spouse, low social network, no hobbies and possession of safety alarm. After a multiple regression analysis of the significant variables, the remaining variables as predictors for loneliness included: number of social contacts self-perceived health, using hearing aid and having a safety alarm.

Fees et al. (1999) examined the relationship between personality cognition, social network and age modeled as predictors of loneliness in older Americans. Self assessed health mediated the relationship. The sample consisted of 208 independently living individuals, 60 to 106 years of age, from the southern region of the United State. Model comparison revealed health did not mediate the relationship significantly but that self-reported loneliness itself mediated between personal characteristics and perceived health. Results indicate anxiety, frequency of telephone contact, and age but not frequency of face to face contact with other or cognitive functioning, affect perceived loneliness. Perceived loneliness mediates the effects of anxiety, frequency of telephone contacts, and age of self-assessed health. Feelings of loneliness decrease one's evaluation of physical well-being.

Krikpatrick et al. (1999) examined the hypothesis that religious beliefs, and particularly beliefs about having a relationship with God contribute to the prediction of (lower levels of) loneliness above and beyond the prediction afforded by perceived available (interpersonal) social support. 123 female and 61 male students (aged 18-22 yrs) served as Ss. Significant religion X sex interactions in the prediction of loneliness were observed for several religion variables. Follow-up analyses suggested that our hypothesis was supported with respect to women, but that, for men, religiousness was either unrelated to or positively related to loneliness.

Holmen et al. (1999) undertook a study in which cognitively impaired (dementia) and intact elderly Ss (aged 75-98 yrs) were interviewed about their present state of mood and how often they experienced loneliness. A geriatric depressions scale measured the present state of mood whereas loneliness was assessed by self report. In both groups, 85% of the Ss reported basic satisfaction with their lives. The greatest difference in response between the 2 cognitive groups was found in the question about having an empty life. Loneliness and sad mood prevailed especially among Ss with cognitive difficulties. It is concluded that experiencing loneliness had a negative influence on the state of mood in both cognitive groups, particularly among persons with cognitive impairment.

Hagerty and Williams (1999) examined the effects of the interpersonal phenomena of sense of belonging, social support, loneliness, and conflict on depression, and to describe the predictive value of sense of belonging for depression in the context of other interpersonal phenomenon. 31 patients with depression (aged 21-75 yrs) and 379 community college students (aged 18-72 yrs) completed questionnaires. Path analysis showed significant direct paths as postulated, with 64% of the variance of depression explained by the variables in the model. Social support had only an indirect effect on depression, and this finding supported the buffer theory of social support, sense of belonging was a better predictor of depression. The study findings emphasize the importance of relationship-oriented experiences as part of assessment and intervention strategies for individuals with depression.

Penninx et al. (1999) examined whether patterns of social network size, functional social support, and loneliness are different for older persons with different

types of chronic diseases. In community based sample of 2,788 men and women (aged 55-85 yrs) participating in the Longitudinal Aging Study, Amsterdam, chronic diseases status, social network size, support exchanges, and loneliness were assessed. Social network size and emotional support exchanges were not associated with disease status. The only differences between healthy and chronically ill people were found for receipt of instrumental support and loneliness. Disease characteristics played a differential role: greater feelings of loneliness were mainly found for persons with lung disease or arthritis, and receiving more instrumental support was mainly found for persons with arthritis or stroke. The specifics of a disease appear to play a (small) role in the receipt of instrumental support and feelings of loneliness of chronically ill older persons.

In view of the fact that previous research has indicated a relation between lack of social skills and loneliness in young adults, Vandeputte et al. (1999) extended the study to older adults' social skills in 2 experiments examining conversational interactions between 65-91 yrs olds, 18-25 yr olds, and mixed-aged dyads. The conversations were coded for social skill using partner attention statements as the measure of skill. The Back Depression Inventory, the UCLA Loneliness Scale, and a measure of social anxiety were administered to study the relation of these psychosocial variables to young and older adults' social skills. In neither study were depression or social anxiety related to self-reported loneliness for either young or older adults. Furthermore, loneliness was not related to young or older adults' social skill as measured by partner attention. However, social anxiety was related to social skill during intergenerational conversations: Both young and older adults who experienced more social anxiety at being paired with a partner from the other age group made fewer partner attentional statement. In addition, both older and young adults exhibited a greater degree of social skills when interacting with young partners.

Rokach (1999) examined the influence of cultural background on an individual's ability to cope with loneliness. Participants were from 3 cultural backgrounds: North American (NAN), South Asian (SASN), West Indian (WIN). 679 18.89 yrs olds (318 men and 361 women) answered on 18-item loneliness questionnaire. Result suggested that NANs use reflection less often than SANs and WINs. NANs had the highest score on the social support network factor. Gender

differences were also found across the cultures and within each culture. In general men did not differ in their styles of coping with loneliness, except in regard to Distancing and Denial and Religion and Faith.

Kim (1999) investigated the mediating effect of two types social support (emotional and tangible support) between ethnic attachment and loneliness in older Korean immigrants. Emotional and tangible social support had three components: network size, network composition, and satisfaction with network members. The sample consisted of 174 older Korean immigrants (aged 60-87 yrs) who lived in a metropolitan area. Telephone interviews were used to collect data using translated Korean versions of the Revised UCLA Loneliness Scale (D. Russell et al., 1980). Ethnic Attachment Questionnaire (W.M. Hurh and K.C. Kim, 1984), and the Revised Social Support Questionnaire (N. Krause and K. Markida, 1990). Emotional and tangible social support network size and satisfaction mediated the effect of ethnic attachment on loneliness. Older Koreans who had stronger ethnic attachment had more emotional and tangible supports, were more satisfied with their supports, and had a lower level of loneliness.

Rotenberg and Flood (1999) examined C.P. Herman and H. Polivy's (1975) restrained eating theory using 2 different methods: situational experimental and dispositional correlational. 58 female college students (aged 17-34 yrs) were administered the revised UCLA loneliness scale, the Beck Depression Inventory (short Form) and the Restraint scale. Subsequently, the students were subjected to either a neutral, sad, or loneliness mood induction and then ate cookies under the pretext of participating in a taste test. Consistent with expectation, dieters tended to consume more food in the loneliness than neutral mood condition, whereas non-dieters displayed the opposite pattern. A comparable pattern was found in the relation between the revised UCLA Loneliness scale and food consumption with respect to Restraint, the amount of food consumed increased as a function of loneliness for high restrained eaters, whereas the amount of food consumed decreased as a function of loneliness for low restrained eaters.

Clinton and Anderson (1999) focuses on the distinction between emotional and social loneliness, particularly within the African American population. This

article provided insight into these overlooked dimensions of loneliness. African American undergraduates (50 men, 50 women) from a large predominantly White, Midwestern University completed measures of social and emotional loneliness, the Revised Self-Monitoring Scale, an index of perceived control and several sociometric questions. Regression analysis indicated social loneliness – a lack of companionship – was inversely related to "number of close students" and Ability to Modify Self-Presentation. For men, emotional loneliness – lack of intimacy with friends – was inversely related to having a reciprocated best friend. For women, emotional loneliness was inversely related perceived control. Sensitivity to the Expressive Behaviour of others was significantly and inversely correlated with emotional loneliness only when individuals had high scores on the perceived control scale. The development of better scales for assessing these 2 critical forms of loneliness was urged.

Ernst and Cacioppo (1999) reviewed the developmental, social, personality, clinical, and counseling psychology literatures on loneliness. Chronic feelings of loneliness appear to have roots in childhood and early attachment processes. Chronically lonely individuals are more likely to be high in negative affectivity, act in a socially withdrawn fashion, lack of trust in self and others, feel little control over success or failure, and generally be dissatisfied with their relationships. Loneliness has been associated with a variety of individual differences, and is also a concomitant of more severe disorders. Although loneliness is prevalent and is associated with numerous negative outcomes, relatively few investigations have examined the efficacy of treatment aimed at alleviating or preventing loneliness. Several investigations raise the possibility of treating loneliness, but the absence of appropriate comparison groups casts doubt on the efficacy of many of these treatments. Correlational studies also suggest that one close friend or romantic partner may be sufficient to buffer those at risk for loneliness. Research on casual processes is sparse, however, and more research is needed to delineate which factors are antecedents and which are consequences of loneliness.

Van Tilburg et al. (1998) has described that on the average, older adults in Italy are lonelier than those in the Netherlands. The results of a study by M. Jytha & J. Jokela (1990) showed that loneliness was more prevalent in regions of Europe where

living alone was rarest and where community bonds were strongest. This inverse macro-level association, an increasing proportion of lonely older people and a decreasing proportion of older people who live alone from northern to southern Europe, could not be explained by differences in individual social integration. The aim of their study was to reinvestigate this association. The data were from surveys conducted in the Netherland (N=3750) and north-western Tuscany, Italy (N=1543). Fewer older adults lived alone in Tuscany than in the Netherlands, which indicates that the Dutch were less integrated. As regards their participation in social organizations and personal networks, the Tuscany older adults were less integrated. To a large extent, loneliness among the Dutch and Tuscans based on differences in social integration could be similarly explained.

Hall-Elston and Mullins (1999) examined the social interactions older persons have with their children, spouses, and/or friends, the perceived emotional closeness present in these social relationships and the extent to which these relationships influence feelings of loneliness. Data from 1303 Ss (mean age 75 yrs) were analyzed using ANOVA. Findings revealed that those who were married with no children or friends experienced the greatest loneliness, and that the emotional closeness experienced within social relationships may not be as important in understanding loneliness as is the simple existence of these relationships.

Stevens and Van Tilburg (2000) carried out study in which in order promote well being and alleviate loneliness among older women, a program was developed to help them improve existing friendships or develop new friendships. In a pilot study 32 female Ss (aged 54-80 yrs) in the program were interviewed on their friendships and feelings of loneliness at 2 points in time, immediately following the course and 1 yr later. Loneliness scores were compared to those of a matched control group from a large nationally representative sample. Both groups were very lonely initially and showed a significant reduction in loneliness 1 yr later. It was found that more women in the friendship course were successful in reducing their loneliness; these women had developed new friendships of varying degrees of closeness and had increased the complexity of their friendship networks. These changes were significantly related to the decline in loneliness.

Rokach and Neto (2000) examined the influence of cultural background on adolescents perceptions of the causes of their loneliness. One hundred Canadian Youth and 206 Portuguese adolescents (aged 13-18 yrs) answered an 82-item questionnaire. The questionnaire was composed of 5 subscales, namely: Personal inadequacies, Developmental deficits, Unfulfilling intimate relationships, Relocation/ significant separation, and social marginality. Participants were asked to endorse those items that in their opinion constituted the antecedents of their loneliness. Results indicated significant differences, between youth of the 2 cultures on the personal inadequacies and Developmental deficits subscale, with Canadian youth scoring significantly higher on both. Gender differences were also examined within and between cultures. Within culture differences were found among Canadian youth, with Canadian females scoring higher on personal inadequacies and Males scoring higher on social marginality.

Rokach (2000) examined the influence of age and sex on the experience of loneliness. 501 male and 210 female Ss (aged 13-80 years) volunteered to answer an 82 item Yes/No questionnaire on their loneliness experience and its meaning. Four age groups were compared: 106 youth (13-18 yrs old), 255 young adults (19-30 yrs old), 314 adults (31-58 yrs old), and 36 seniors (60-80 yrs old). Within and between sex comparisons indicated that loneliness is affected by Ss age and sex.

Long and Martin (2000) examined the effects of personality, attachment, and dimensions of family solidarity on the loneliness of oldest old adults. (i.e. 85 yrs and older) and their adult children (aged 42-78 yrs). Parent-child dyads were formed with data collected from 100 parents and their children. Results from path analysis indicated that oldest old adult loneliness was reduced by affection both for and from their children. Although an anxious personality decreased affection, perceptions of attachment to children increased feelings of affection. In addition, parents and children who had anxious personalities were more likely to be lonely, whereas loneliness was decreased for those with an extraverted personality. Children's loneliness was also decreased by association with their parents and by the quality of their friendships. Perceptions of childhood attachment to parents increased current affection and association with and fulfillment of parent's expectation.

Cohen (2000) discusses the development and effects of loneliness in the elderly. The need for mental health specialists to identity what factors predispose an individual to the phenomenon as well as those that precipitate it is noted. The usage of social interventions and psychological counseling either alone and in combinations is promoted as an effective form of treatment. It is concluded that, given the prevalence of loneliness and the frequency of adverse effects on health in later life, the topic should be considered a more prominent mental health matter in the future.

Rokach et al. (2000) explored the influence of cultural background on the causes of loneliness. 375 participants from North America (Canada) and 375 from Croatia (aged 21-80 years) volunteered to answer on 82 item questionnaire which examined the antecedents of their loneliness experiences. Five factors comprise the causes of loneliness: Personal inadequacies, developmental deficits, unfulfilling intimate relationships, Relocation/ significant separation, and social marginality. North Americans scored significantly higher on all 5 factors. Gender differences within cultures were also noted.

Rokach and Bacanli (2001) examined the influence of cultural background on the perceptions of loneliness antecedents. In their study, 711 Canadians, 568 Turks, and 398 Argentinean (aged 13-83 yrs) answered on 82-item questionnaire composed of 5 subscales, namely: Personal inadequacies, Developmental deficits, Unfulfilling intimate relationships, Relocation/significant separation, and Social Marginality. Ss were asked to endorse those items which in their opinion, constituted the causes of their loneliness. Result showed significant difference among the 3 cultures. Canadians had the highest mean scores on all subscales, while the Turkish Ss had the lowest mean scores on personal inadequacies and developmental deficits. Gender differences also were examined within and between cultures.

Holmen, Ericsson and Winblad (2000) investigate loneliness, both social and emotional, in non-demented and demented elderly people. 589 Ss (aged 75-90+ yrs) answered the question about social loneliness (often being lonely) in the Kungsholmen longitudinal project. All Ss were examined extensively to reach a diagnosis and to determine the dementia level: non-demented, and questionably, mildly, moderately, or severely demented based on Mini Mental State Examination

Scores. Data were collected through structured interviews on subjective interviews on subjective social loneliness as well as emotional loneliness (feelings of loneliness, from often to never) and backward variables (age, sex, housing and housing conditions). Result showed that Non-demented Ss reported themselves to be lonely significantly less often compared to demented Ss, but there were no differences in the emotional experience of loneliness. Social loneliness was more common in the different levels of dementia and increased with reduced cognitive functioning, while emotional loneliness decreased. Living together with some one and living in one's own apartment showed a positive influence on feelings of loneliness.

Van Baarsen et al. (2001) investigated the unidimensional versus bidimensional nature of the De Jong-Gierveld Loneliness scale (DJGLS) using 2 complementary approaches (an investigation on the basis of the internal association structure of the items based on item response theory and an external validity study based on the theoretical interpretation of item content and the association of the items with other variables) in an older population. The DJGLS measures high and low levels of both emotional and social aspects loneliness. Ss were participanted in another study focusing on living arrangements and social networks of older people. A total of 4,063 55-89 yr olds completed the DJGLS in a face-to-face interview. Ss were also asked about their marital status, social skills, self esteem, need for affiliation, and network characteristics. The results suggested that the DJGLS is appropriately regarded as bidimensional for samples of older people. Further, findings showed that theoretically relevant background, personality, and network factors are differently related to feeling of emotional and social loneliness.

Green et al. (2001) examined social network correlates of social and emotional loneliness to demonstrate that social and emotional loneliness are different constructs and investigated the possibility of age differences in the relationship between loneliness and social network characteristics. 91 college students (mean age 20 yrs) and 110 older adults (mean age 71 yrs) completed a loneliness scale that was designed to measure social and emotional loneliness (P. Shover & K. Brehnan, 1991; M.T. Wittenberg, 1986) and the UCLA Loneliness scale (D. Russell et al., 1980). Results indicated that for both young and older adults, social and emotional loneliness were moderately correlated with one another and had differential network correlates.

Likewise, for both age groups, emotional loneliness was related to the presence of a romantic partner in the network, although this relationship was stronger for the older adults. Correlates of social loneliness also differed between young and older adults. The presence of a close other and size of the network predicted social loneliness for young adults, whereas average closeness of the network predicted social loneliness for older adults.

Rokach et al. (2001) examined the influence of cultural background on the experience of loneliness in 750 Ss (aged 21-80 years). Three hundred and seventy participants from North America and 375 from Croatia volunteered to answer on 82 items questionnaire which examined the quality of their loneliness experiences. The factors which comprise the experience of loneliness are Emotional distress, social inadequacy and alienation, growth and discovery, interpersonal isolation, and self-alienation. Results indicated that cultural background, indeed effects the experience of loneliness. North American scored higher on all five factors, and a similar trend was evident when men and women were compared across cultures.

Rokach (2001) examined the influence of age and gender on coping with loneliness. 711 participants from all walks of life volunteered to answer an 86 items yes/no questionnaire, reflecting on the beneficial coping strategies, which they have used to deal with the pain of loneliness. Four age groups, were compared: youth (13-18 yrs old), young adults (19-30 yrs old), adults (31-58 yrs old) and seniors (60-80 yrs old). Within and between gender comparisons were also done. Results revealed that loneliness is approached and dealt with more effectively by adult groups, and that women appear to cope better than men do with loneliness.

Johnson et al. (2001) had described that family environment is related to characteristics of adolescents personal development and social interactions. Although potentially different for males and females, decreased family cohesion and increased interparental conflict can inadvertently provide family environments that are associated with increased feelings of loneliness, which may be associated with problems of in adolescent's social interactions (i.e., social anxiety and social avoidance). Analysis of responses from 124 late adolescents (aged 17-21 yrs) revealed that feelings of loneliness were related to perceived level of interparental conflict for

males and females, decreased family cohesion for females. Furthermore, late adolescents' feelings of social anxiety and social avoidance were related to their feelings of loneliness. The findings in this study showed how deteriorated family systems may provide contexts that are associated with adolescents' feelings of loneliness as well as their ability to engage in social interactions outside of the family system.

McInnis and White (2001) has proposed a phenomenological inquiry using A. Giorgi's research methodology was undertaken to explore and describe the meaning of loneliness for older adults. 20 participants (aged 71-85 years) were interviewed and 1,385 naïve meaning units were extrapolated from tape-recorded verbatim transcripts. These units were clustered into 5 major themes describing the loneliness experience. The findings were described and discussed relative to the literature on loneliness. Implications for mental health nursing were presented. The typology of major themes, naïve units, and Ss description were appended.

Caciopp et al. (2002) undertook two studies using cross-sectional designs and explored four possible mechanism by which loneliness may have deleterious effect on health: health behaviours, cardiovascular activation, cortisol levels, and sleep. In study 1, they assessed autonomic activity, salivary cortisol levels, sleep quality, and health behaviours in 89 undergraduate students selected based on pretests to be among the top or bottom quintile in feelings of loneliness. In study 2, they assessed blood pressure, heart rate, salivary cortisol levels, sleep quality, and health behaviours in 25 older adults whose loneliness was assessed at the time of testing at their residence. As a result, total peripheral resistance was higher in lonely than non-lonely participants, whereas cardiac contractibility, heart rate and cardiac output were higher in nonlonely than lonely participants. Lonely individuals also reported poorer sleep than non lonely individuals. Study 2 indicated greater age related increase in blood pressure and poor sleep quality in lonely than nonlonely older adults. Mean salivary cortisol levels and health behaviours did not differ between groups in either study.

Rokach and Neto (2002) examined the influence of cultural background on the experience of loneliness of people aged 60+ years. 141 participants (aged 60-83 yrs) were recruited from Canada and Portugal. They answered an 82-item questionnaire.

The questionnaire is composed of 5 subscales, namely: Emotional distress, social inadequacy and alienation, Growth and discovery, Interpersonal isolation, and Self-alienation. Results indicated that the experience of loneliness in old age transcends cultural, geographical and social differences. No significant differences among the scores of the aged in the 2 cultures were found, nor was there a gender main effect found.

McWhirter et al. (2002) examined the relationships among types of loneliness, empathy, coping skills and self-esteem among a sample of high risk adolescents enrolled in an alternative high school in the US (N=75, 43 male and 32 female; mean age 17 years). Results of 2 forward-selection multiple regression analyses with intimate loneliness and social loneliness serving as criterion variables, and with self-esteem, empathy, perspective taking, and 5 types of coping serving as predictor variables, reveal that low self-esteem and low social coping significantly predicted high intimate and high social loneliness. Low emotional coping also significantly predicted high intimate loneliness but not high social loneliness. Implications for intervention and research were discussed.

Pinquart and Sorensen (2001) reported a meta-analysis of the correlates of loneliness in late adulthood. A U-shaped association between age and loneliness was identified. Quality of social network was correlated more strongly with loneliness, compared to quantity; contacts with friends and neighbours show stronger associations with loneliness, compared to contacts with family members. Being a women, having low socio-economic status and low competence, and living in nursing homes were also associated with higher loneliness. Age differences in the association of social contacts and competence with loneliness were investigated as well.

Pinquart and Sorensen (2003) investigated risk factors for loneliness in later life. Loneliness was weakly correlated with age, but the correlation was greater for the oldest old. Social contact was negatively associated with loneliness, and the effect of the quality of social contacts was larger than the effect of the quantity of contacts. It was found that contact with friends protect more from loneliness than contact with adult children and other relatives but this pattern was weaker in older samples. Being unmarried, having low levels of physical health, low everyday competence, low

socio-economic status, being female and living in nursing home were also associated with higher loneliness. In addition, association of marital status, contact deficits, health problems, and female gender with loneliness were stronger in older sample, whereas institutionalization becomes less important in predicting loneliness in older samples.

Alpass and Neville (2003) investigated relationships between loneliness, health, and depression in 217 older men (aged 65-89). Participants completed self-report measures of loneliness, social support, depression, and physical health. Regression analysis showed that a diagnosis of illness or disability was unrelated to depression, however self-reported health was associated with depression, with those reporting poorer health experiencing greater depression. Social support variables were unrelated to depression. The most significant relationship to depression was that of loneliness, with lonelier men reporting higher scores on the Geriatric Depression Scale (GDS). Results suggested that depression is often a response to declining health and functional impairment in the older adult, the present findings suggested that social isolation may also influence the experience of depression. Age-related losses such as loss of professional identity, physical mobility, and the inevitable loss of family and friends can affect a person's disability to maintain relationships and independence, which in turn may lead to a higher incidence of depressive symptoms.

Hawkley et al. (2003) has described prior lab research that revealed higher basal total peripheral resistance (TPR) and lower cardiac output (CO) in lonely than in nonlonely young adults. In this study, experience sampling was used to obtain ambulatory blood pressure, impedance cardiography; reports of activities, appraisals, interactions, and health behaviours. Results confirmed that loneliness predicted higher TPR and lower CO during a normal day. Loneliness did not predict differences in time spent alone, daily activities, or health behaviours but did predict higher stress appraisals and poorer social interactions. Independent of loneliness, interaction quality contributed to TPR. Loneliness differences were not mediated by depressed affect or neuroticism, social support mediated loneliness differences in stress and threat concomitants of loneliness were comparable for men and women.

Rokach et al. (2002) examined the influence of cultural background on strategies used to cope with loneliness. 375 participants from North America and 375 from Croatia volunteered to answer an 86 items questionnaire which examined how they coped with loneliness. Subjects were aged 21-80 yrs. Six factors compared the variety of coping strategies: Reflection, and acceptance, self development and understanding, social support network, distancing and denial, religion and faith, and increased activity. Results indicated that cultural background did indeed affect the manner in which people cope with loneliness. North Americans scored higher on all six factors and a similar trend was evident when men and women were compared across cultures.

Van Tilburg et al. (2004) reported differences in the level of loneliness on the basis of national differences in partnership, kinship, and friendship, which were assumed to be related to cultural standards within a society. Differences were examined among married and widowed older adults aged 70 to 89 years living independently in the Netherlands (N=1,847), Tuscany, Italy (N=562), and Manitoba, Canada (N=1,134). Loneliness was measured with an 11-item scale. Results showed that the Manitobas were high on emotional loneliness and the Tuscans were high on social loneliness. Partner status expected, the determinants were nearly the same across the three locations. Differential item functioning (DIF) related to three locations was observed for most items. Interactions with gender and availability of a partner relationships were observed.

Steptoe et al. (2004) carried out study in which the revised UCLA loneliness scale was completed by 240 working men and women aged 47-59 years, and related to affective state and neuroendocrine, cardiovascular, and inflammatory responses. Loneliness scores were not associated with gender, age or socio-economic positions, but were lower in married than single or divorced participants, and were positively related to social isolation, low emotional support, ratings of depression, hopelessness and low self-esteem, and to reported sleep problems. Diastolic blood pressure reactions to acute mental stress were positively correlated with loneliness in women but not men. Lonely individuals also displayed significantly greater fibrinogen and natural killer cell responses to stress. The cortisol response over the first 30 min following waking was positively associated with loneliness after adjusting for waking

cortisol value, sex, socio-economic status, smoking, time of waking, and body mass. It was concluded that loneliness is a psychological experience which may also relevant to health.

Yeh and Lo (2004) aimed to describe the characteristics of the elderly population living alone, and to examine how living alone relates to feeling lonely. Interviews were conducted with a stratified random sample of 4,859 elderly individuals living in Kaohsiung, Taiwan. Variables collected included demographic information, living alone or not, activities of daily living (ADL), instrumental activities of daily living (IADL), Short Portable Mental Status Questionnaire (SMPSQ), chronic conditions, perceived social support, and a subjective measure of feeling lonely. Using logistic regression, it was found that factors associated with living alone included gender, marital status, occupation, source of income, religion, instrumental activities of daily living (IADL). Living alone was, in turn, related to decreased levels of both perceived social support and feeling lonely after adjustment for potential confounders. Man aging retired life is important for adult elders, particularly for men. Lack of social support is common among the elderly community who live alone, could be a main reason for this group to feel lonely. As loneliness is linked to physical and mental health problem, increasing social support and facilitating friendship should be factored into lifestyle management for communities of elderly.

Duncan and Weissenburger (2003) tested the hypothesis that brief mediations practiced daily over short period of time would increase individual's well being and decrease their susceptibility to loneliness. Twenty graduate students in a transpersonal psychology course served as participants in the study. Thirteen of the students practiced a brief mediation program, while seven students in the same class formed an untreated group who did not mediate. Their progress was measured by comparing their pre- and post-test scores on the outcome of Questionnaire-45 (OQ-45) and the UCLA Loneliness scale. Results showed that the brief mediation program contributed to a decrease in feelings of loneliness. Exposure to the transpersonal psychology class and mediation contributed to positive changes in their of well-being.

Rokach (2003) investigated the causes of loneliness as perceived by Multiple Sclerosis (MS) patients, those diagnosed with cancer, and the general population. Three hundred and twenty-nine MS patients, 315 patients, and 391 participants from the general population answered a 29-item questionnaire. Results indicated that with the exception of personal adequacies and developmental deficits, those afflicted with MS and cancer perceived the causes of loneliness to be significantly different from those of the general population. Men and women in each population differed significantly in their perception of loneliness.

Van der Geest (2005) described a life-conditions of elderly people in a rural community of Ghana. It deals with the paradoxical situation of the elderly people who are still engaged in social activities and yet experience loneliness. It is argued that inspite of the respect given to them, elderly people are denied what they regard as the most valuable proof of respect and companionship: listening to their wisdom and advice. Their loss of that ultimate respect constitutes an experience of loneliness. The article is part of broader anthropological study on social and cultural meanings of growing old in a rural Ghanaian community.

Rokach and Neto (2005) examined the influence of age and culture on the perceived causes of loneliness. One thousand, three hundred and forty-seven Canadian and Portuguese participants from all walks of life volunteered to answer an 82-item yes/no questionnaire reflecting on the causes of their loneliness. The questionnaire used in this study is composed of the factors that describe causes of loneliness: Personal inadequate, Developmental deficits, Unfulfilling intimate relationships, Relocation/significant separations, and social marginality. Gender differences between and within the groups were also examined. Within and between culture and age comparisons were also done. Results indicated that the causes of loneliness are perceived differently depending on one's age and culture.

Stek et al. (2005) studied the relationship between the presence of depressive symptoms and all-cause mortality in old age, especially the potential distorting effect of perceived loneliness.Method: Within a prospective population-based study of 85-years olds, the 15-item Geriatric Depression Scale and the Loneliness Scale were annually applied in all 476 participants with a Mini-Mental State Examination score

of 18 points or more. Result showed that Depression was present in 23% and associated with marital state, institutionalization, and perceived loneliness. When depression and perceived loneliness were assessed during follow-up, neither depression nor perceived loneliness had a significant effect on mortality. However, those who suffered from both depression and feelings of loneliness had a 2.1 times higher mortality risk. It was concluded that the data suggest that the increased mortality risk attributable to depression in the presence of perceived loneliness may result from motivational depletion.

Orzeck and Rokach (2004) examined the influence of drug cessation on the experience of loneliness. Drug abusers during their stay in detox centers were compared to drug abusers who were in a methadone maintenance program, and those two groups were again compared to a nonusers of drugs. A total of 304 participants from all three groups volunteered to answer a 30 item yes/no questionnaire, reflecting on their experience of loneliness and what it meant to them. The factors which compose the multidimensional loneliness experience are emotional distress, social inadequacy and alienation, growth and discovery, interpersonal isolation, self-alienation. Results revealed significant differences between the scores of the three groups, however only the detox and the general population samples had significantly different subscale scores.

Beal (2006) found older women report more loneliness than male peers. Life changes, including widowhood and relocation, are associated with increased vulnerability to loneliness. Gender, social, cultural factors influence the experience of loneliness in older women. Cognitive and interactionalist theoretical approaches to loneliness have utility for nursing practice and research with older women who experiencing loneliness.

Rokach et al. (2006) examined the qualitative aspects of that loneliness. Five hundred ninety three participants volunteer to answer a 30-items Yes/No questionnaire. Those with physical disabilities were compared to the non-disabled (general population), and then further divided into five homogeneous subgroups (i.e. those with multiple sclerosis, Osteoporosis, Parkinson's, arthritis and "other" sample

who are healthy and not chronically ill. Results indicated that the loneliness of those with physical disabilities differed significantly from that of the general population.

Lauder et al. (2006) investigated differences in health behaviours (smoking, overweight, BMI, sedentary, attitudes toward physical activity) in lonely and nonlonely groups. Lonely individuals were more likely to be smokers and more likely to be over-weight obese. The lonely group had highest body mass index scores controlling for age, annual income, gender, employment and marital status. Logistic regression revealed no differences in sedentary life styles. Lonely individuals were significantly, less likely to believe it was desirable for them to lose weight by walking for recreation, leisure or transportation. The finding provided support for an association between health behaviours, loneliness and excess morbidity reported in previous studies.

Aday, Kehoe and Farney (2006) examines the influence of later-life friendships and senior center activities on the health and well-being of aging women living alone. Based on the findings from 274 women living alone it was found that the senior center is an excellent environment where new supportive friendships can easily be formed. These friendships and other center activities have positive mental and physical outcomes. Using a comparison group of 171 elderly women living with their spouses, it was discovered that women who lived alone participated in center activities more frequently and, as a result, also created a social network that extended outside of the center environment.

Paul, Ayis and Ebrahim (2006) described with the growth in the number of older people, an increase of mental health problems might be expected. Reducing the amount of suffering and dependence due to poor mental health in old age is a priority requiring a good understanding of the determinants of psychological distress. The objectives of study were: (a) to measure the prevalence of psychological distress and loneliness in old men and women living in the community, (b) to clarify the association between psychological distress, health and other explanatory variables and (c) to determine relationship between loneliness psychological distress. They performed a cross-sectional study of 999 people aged 65+. The variables studied were psychological distress (GHQ-12) and self-reported loneliness. Result indicated the

prevalence of psychological distress was 20%. Illness and disability are related to psychological distress in old age; the feeling of loneliness is the single most important predictor of psychological distress, and not knowing neighbours increases the probability of depression. Attempts to improve detection and management of psychological distress in sick older people in those who appear isolated and express loneliness should be evaluated.

Garden and Rettew (2006) carried out study in which 50 chatroom users responded online to the satisfaction with life scale, the Revised UCLA Loneliness Scale, and demographic questions which included time spent per week in Internet chatrooms. Time spent in chatrooms was positively correlated with loneliness but only weakly and negatively related to the satisfaction with life.

Nilsson, Linstrom and Naden (2006) investigated to explore how loneliness is described in literature and research. The study employed a hermeneutic approach rooted in the ideology of humanistic science in a caritative nursing tradition. Data sampling for the study was completed over two different periods of time (1998 and 2004). The main findings were that loneliness is understood as a complex dimension in our lives and it can be experienced at many levels. Through the survey of the theoretical material, loneliness may be understood as a structural dimension of existence and not as an illness. The deep dimension of loneliness, however, can entail suffering that is possibly so intoreable that it may turn towards becoming an illness. Loneliness is assumed as something we are, an ontological structure in our existence. Loneliness can therefore be turned into suffering as well as into health. It is perhaps in the silent reflective loneliness that we paradoxically develop a greater understanding of the benefits of togetherness. It is therefore concluded that the performance of loneliness is not a psychological dysfunction.

Cacioppo et al. (2006) found that extent to which loneliness is a unique risk factor for depressive symptoms was determined in population based studies of middle aged to older adults, and the possible causal influences between loneliness and depressive symptoms were examined longitudinally in the 2nd study. In study 1, a nationally representative sample of persons aged 54 and older completed a telephone interview as a part of a study of health and aging. Higher levels of loneliness were

associated with more depressive symptoms, net of the effects of age, gender, ethnicity, education, income, marital status, social support, and perceived stress. In study 2, detailed measures of loneliness, social support, perceived stress, howstility, and demographic characteristics were collected over a 3-year period from a population based sample of adults ages 50-67 years from Cook Country, Illinois. It showed that loneliness was again associated with more depressive symptoms, net of demographic cavariates, marital status, social support, hostility, and perceived stress. Latent variable growth models revealed reciprocal influences over time between loneliness and depressive symptomatology. These data suggested that loneliness can act in a synergistic effect to diminish well-being in middle aged and older adults.

Hawkley et al. (2006) examined how loneliness and co-occuring psychological factors were related to indices of cardiac vascular and endocrine functioning. Extending prior research, the authors found that loneliness was associated with elevated systolic blood pressure (SBP) and age-related increases in SBP, net of demographic variables, health behaviour variables, and the remaining psychosocial factors. Loneliness was not associated with differences in autonomic or endocrine functioning. Although the results are limited by the cross-sectional methods used, they are consistent with the hypothesis that cardiovascular disease, contributes to increase morbidity and mortality lonely individuals.

Constanca, Salma, and Shah (2006) stated with the growth in the number of older people, an increase of mental health problems might be expected. Reducing the amount of suffering and dependence due to poor mental health in old age is a priority requiring a good understanding of the determinants of psychological distress. The objectives were: (a) to measure the prevalence of psychological distress and loneliness in old men and women, living in community, (b) to clarify the association between psychological distress, health and other explanatory variables, and (c) to determine relationship between loneliness and psychological distress. They performed a cross-sectional study of 999 people aged 65+. The variables studied were psychological distress (GHQ-12) and self-reported loneliness. The prevalence of psychological distress was 20%. Illness and disability are related to psychological distress in old age; the feeling of loneliness was found to be the single most important predictor of psychological distress, and not knowing neighbours increased the

probability of depression. Attempts to improve detection and management of psychological distress in sick older people, in those who appear isolated and express loneliness should be evaluated.

Bhatia et al. (2007) conducted a study on the health-related problems and loneliness among the elderly in different micro-environment groups. Participants were aged person of age 65 years and above from urban and rural area of Chandigarh. Cross-sectional design was used in the study and t-test and Z test was used as statistical analysis. Results showed that out of the total 361 aged persons of chandigarh, 311 (86.1%) persons reported one or more health-related complaints, with an average of two illnesses. The illness was higher among the females (59.5%) as compared to males (40.5%). The main health-related problems were disorders of the circulatory system (51.2%), musculoskeletal system and connective tissue (45.7%). It was also found that loneliness was prevalent more in females (72.8%) as compared to males (65.6%). Loneliness was more prevalent among persons who lived alone (92.2%) as compared to those who lived with their spouse (58.9%) or when husband and wife lived with the family (61.4%). It was higher among the widows (85.2%) and widowers (75.8%) who lived with family as compared to the aged who lived with the spouse (58.9%) and aged husband and wife who lived with family (61.4%). It was concluded that special geriatric services should be started in the hospital as the majority of the aged have one or more health-related problems. The aged persons should be involved in social activities to avoid loneliness among them.

Liu and Guo (2007) in a study investigated whether loneliness was associated with quality of life and examined the influence of socio-economic factors in the empty nest elderly. A 36-item short-Form Health Survey (SF-36) and UCLA Loneliness Scale (UCLA-LS) were used to assess the quality of life and loneliness for 275 empty nest and 315 not empty nest rural elders in a country, China. T tests, Person's correlations and linear regression analysis were used to examine the difference in SF-36 and UCLA-LS scores, correlations of the two scores between the two groups, and socio-economic determinants of loneliness among the empty nest elders. Results showed that Empty nest group, in comparison with not empty nest group, had higher level of loneliness (95% confidence internal [CI] = -3.361 to -.335), lower physical (95%, CI = .228 to 6.044) and mental (95% CI = .866 to 6.380) scores.

Loneliness was negatively correlated with all the 36-item Short Form Health Survey scales in both groups. Social supports and income were negatively associated with loneliness, whereas education level and being single were positively associated with loneliness for the empty nest group. It was concluded that reducing the level of loneliness may be helpful to improve the quality of life for the empty nest elders.

Grov et al. (2009) conducted a study in which they demonstrated correlations between depression, loneliness, health, and HIV/AIDS related stigma, there has been little evaluation of these associations among HIV-positive adults over the age of 50. Data for these analyses were taken from the Research on Older Adults with HIV (ROAH) study of 914 New York city-based HIV positive men and women over the age of 50. Results have found that in total, 39.1% of participants exhibited symptoms of major depression (CES-D > 23). Multivariate modeling successfully explained 42% of the variance in depression, with depression being significantly related to increase HIV-associated stigma, increased loneliness, decreased cognitive functioning, reduced level of energy, and being younger. It was concluded that these data underscore the need for service providers and researchers to assert more aggressive and innovative efforts to resolve both psychological and physical health issues that characterize the graying of the AIDS epidemic in the United States. Data suggested that focusing efforts to reduce HIV-related stigma and loneliness may have lasting effects in reducing major depressive symptoms and improving perceived health.

SECTION II

LEISURE TIME ACTIVITIES

Another consideration that motivated the present author to undertake this proposed research was the existence of some evidence showing relationship between leisure time activities and general health of people.

Guinn (1999) examined the relationship between individual differences in the orientation toward intrinsic motivation in leisure behaviour and the life satisfaction of retired persons. 405 Ss, aged 57-92 yrs were selected from age-segregated mobile home parks located in a popular retirement area. Data were gathered through a self-

report instrument consisting of a life satisfaction index, intrinsic leisure motivation scale, and selected demographic variables. Results showed significant positive relationships between life satisfaction and the intrinsic motivation dispositions of self-determination, competence and challenge. Challenge a tendency toward seeking leisure experiences that stretch one's limits and provide novel stimuli, offered the most explanatory power relative to Ss' life satisfaction scores.

Griffin and McKenna (1998) examined the extent to which a number of variables may influence the amount and variety of leisure participation, leisure satisfaction, and life satisfaction of 104 elderly individuals (72% female, aged 65-98 yrs) who were in good health and living independently in the community. The association between socio-demographic variables and leisure participation and satisfaction was explored. Multiple regression analysis revealed that less frequent leisure participation was associated with older age, poorer health and lack of an independent means of transport. Participation in a reduced variety of leisure activities was also linked to an absence of independent transport. None of the variables were found to influence participants' generally positive expressions of leisure and life satisfaction. It was concluded that, while the amount and variety of leisure activities undertaken might decrease in people with specific characteristics, leisure satisfaction remains high, due to continued participation in a more limited but still valued number of activities. Adjustment of expectations to accommodate reduced leisure participation may occur in this population and contribute towards the maintenance of high levels of life satisfaction.

Parry and Shaw (1999) used an alternative feminist framework to explore the experiences of menopause and midlife, and to examine the impact of leisure on these experiences. In-depth interventions were conducted with 5 women, all of whom were currently experiencing menopause. The findings indicated that menopause and midlife were inextricably linked for these women, through the emotional challenges that they were experiencing and through the realization of aging. Leisure was shown to have a number of beneficial outcomes. Physically active leisure enhanced health and physical and emotional well-being. In addition, although some leisure activities provided women with a sense of familiarity, security, and continuity other practices allowed women to develop new interest, to focus on themselves, and to improve their

self-attitudes. Finding an appropriate balance between these various outcomes of leisure may help women to negotiate their journey through the transitional years of menopause and midlife.

DiBona (2000) identified the influence of different variables on the leisure experience. The study aimed to establish: if there was a difference in the needs satisfied by leisure between people of different ages, sex, and relationship and parental status (people with or without or cohabiting with a partner or children); whether or not different needs were satisfied by different leisure activities, and whether the adapted form of the leisure satisfaction scale (LSS) (Beard and Ragheb, 1980) measured leisure satisfaction. 65 nurses completed an adapted form of the LSS for 3 leisure activities that they engaged in and rated their overall satisfaction with leisure on a scale of 1 to 10. The findings lent support to the use of the adapted form of the LSS as a valid measure of leisure satisfaction. The findings suggested that leisure satisfaction was not affected by demographic factors, but they supported previous findings that leisure satisfaction was affected by different leisure activities to meet individual needs. It also suggested the potential benefit of using the LSS in occupational therapy.

Holmes and Dorfman (2000) investigated the relationship between 8 specific health conditions and activities often engaged in by retirees: formal and informal social activities, active leisure, and home maintenance activities. Data are based on a sub sample of 502 retired individuals (aged 60-94 yrs) from the Americans' changing Lives Survey. Multiple regression analyses, controlling for predisposing socio-demographic characteristics, showed that lung-disease, diabetes, and broken bones were negatively associated with physically demanding activities, such as active leisure and home maintenance activities. Stroke restricted frequency of walking as well as informal social activities. Certain health conditions, however, showed few effects on activities in retirement, suggesting that relatively little functional limitation may be associated with certain health problems, or that older persons make adjustments that allow them to participate in retirement activities.

Henderson and Ainsworth (2000) examined how gender and race were experienced in perceptions about physical activity for older (over the age of 40 yrs)

African American and American Indian women. From a leisure analysis perceptive, the study focuses on freely chosen and enjoyable physical activity as it related to what exercise physiologists have termed leisure time physical activity. 30 African American women (mean age 57 yrs) and 26 American Indian Women (mean age 56 yrs) completed interviews that explored how socio-cultural perspectives are related to perceptions about physical activity. Results showed that gender and other socio-cultural factors influenced physical involvement on a continuum from negligible to significant. Both groups showed evidence that opportunity for physical activity in their free time did not always exist for them. For the African American Ss, history and daily living issues were important factors limiting their involvement. Marginality limited American Indian Ss, but their cultural pride was often a source of physical activity. The juxtaposition of cultural and physical values emerged as a determinant of physical activity involvement among the women in this study.

Schooler and Mulatu (2001) carried out study in which by using data from a representative longitudinal survey, the authors provide strong evidence that complex leisure time activities increase intellectual functioning for workers and nonworkers. Ss were 315 men and 320 women aged 41-88 yrs. Although the effects were relatively moderate, both the present article and its predecessor on the effects of paid work (C. Schooler, M. Mulatu, & G. Oates, 1994) showed that, even in old age, carrying out complex tasks has a positive effect on intellectual processes. In both cases, initially high levels of intellectual functioning led to high levels of environmental complexity, which in turn raised levels of intellectual functioning, thus providing a pathway of intellectual functioning, thus contributing to the high correlation of intellectual functioning over a 20-year period in middle and late adulthood. The present findings indicated that even in old age carrying out substantively complex tasks builds the capacity to deal with the intellectual challenges such complex tasks builds the capacity to deal with the intellectual challenges such complex environments provide.

Lennartsson and Silverstein (2001) examined whether engagement with life (involvement in social, leisure, and productive activities) produced a survival advantage among oldest old persons in Sweden. Survival was investigated with respect to activities that involved (a) social integration, (b) physical mobility, and (c) neither social nor physical aspects. The authors also investigated the degree to which

any observed survival benefits were related to prior health differences that select older adults into active roles. Baselines data was derived from the Swedish Panel study of living conditions of the oldest old, a nationally representative sample of persons aged 77 years and older. Analysis revealed 4 domains of activities that lie along 2 basic dimensions: solitary social and sedentary active. Greater participation in solitary-active activities significantly reduced risk of mortality when all other activity domains and health factors were controlled. Although most of the observed associations between activity involvement and survival are a byproduct of the confound between poor initial health and low activity levels, solitary activities have a positive influence on the survival of very old individuals, especially men, suggesting that non social aspects of activities may promote health and longevity in late old age.

McHale et al. (2001) assessed links between free-time activities in middle childhood and school grades, conduct, and depression symptoms both concurrently and 2 years later, in early adolescence. It also explored two mechanisms that might underlie activity – adjustment links: whether the social contexts of children's activities mediate these links, child effects explain these connections, or both. Participants were 198 children (mean age = 10.9 years) in year 1, and their parents. In home interviews in years 1 and 3 of the study, mother's rated children's conduct problem, children reported on their depression symptoms, and information was collected on school grades from report cards. In seven evening phone interviews, children reported on the time they spent in free-time activities during the day of the call and their companions in each activity. Links were found between the nature of children's free time activities and their adjustment. The social contexts of free time activities explained activity – adjustment links to a limited degree, with respect to child effects, evidence also suggested that better adjusted children became more involved in adaptive activities over time.

Strain et al. (2002) examined changes in leisure activities of older adults over an 8-year period, and associated sociodemographic and health characteristics. Data were from a longitudinal study conducted in Winnipeg, Manitoba, Canada; 380 respondents were interviewed in person in both 1985 and 1993. Changes in ten specific activities and the overall number of activities continued were examined. Theater/movies/spectator sports and travel were the activities least likely to be

continued over the 8-year period, watching television and reading were most likely to be continued. Results showed that characteristics significantly related to changes in activities were age, gender, education, and self-rated health in 1985 as well as changes in marital status, self-rated health, and functional ability between 1985 and 1993, although no consistent pattern emerged. Leisure education is discussed as a means of introducing modifications to enhance older adults' participation in desired activities.

Kleiber, Hutchinson and Williams (2002) reviewed the leisure coping literature published since 1980, as well as work on the dynamics of coping and the impact of pleasant events. The literature review is divided into 3 parts: (1) literature related to the disruptions that occur as a result of negative life events; (2) the extant literature related to the role of leisure in coping with stress caused by negative life events, and (3) literature specifically concerned with the dynamics of coping and the influence of pleasant events in the coping process. The authors identify 4 distinguishable functions of leisure, 2 functions are related primarily to coping and 2 that identify the role of leisure in bringing about a more complete course of adjustment.

Nour et al. (2002) notes that leisure education seems to be an important step for older adults who have difficulty adjusting psychologically after a stroke. A randomized clinical trial designed tested this hypothesis. 13 Ss were assigned to 2 groups, an experimental leisure, educational group and a placebo "friendly visit" group, and received 10 individual sessions at home after discharge from rehabilitation. Baseline assessments were carried out upon admission to the study and upon discharge (i.e. 1st session at home, and the 2nd assessment, 10 wks later). The Ss receiving the home leisure educational program significantly better on physical and total quality of life measure than the placebo Ss.

Specht et al. (2002) noted that although occupational therapists emphasize a balance among the 3 occupational areas of self-care, productivity, and leisure in people's lives, leisure often is focused on less than the other areas in both the research literature and clinical practice. Very little research has been conducted on the benefits of leisure activities in adults with congenital disabilities. This article is a secondary analysis of the interview protocols of 9 adults (aged 30-50 yrs) with either cerebral

palsy or spina bifida. The primary purpose of the interview was to determine protective processes surrounding turning points in the lives of persons with disabilities. This secondary analysis allowed the authors to determine the benefits and meaning of leisure for this population. Consistent with literature that focused on either persons without disabilities or persons with acquired disabilities, the participants in the present study reported that involvement in leisure activity provided mental and physical health benefits, enjoyment, opportunity to develop a self-concept and increase self-esteem, and opportunities to build and enhance social relationships. All these benefits enabled people to find meaning in life through doing, belonging, and understanding self in the context of their worlds.

Silverstein and Parker (2002) tested whether change in leisure activities over a 10 year period was associated with retrospectivity assessed change in quality of life among older people in Sweden. Hypotheses were tested using a nationally representative sample of 324 older Swedes (aged 66-75 in 1981) living in the community, surveyed in 1981 and 1922. 15 leisure activities were divided into 6 domains: culture-entertainment, productive personal growth, outdoor-physical, recreation-expressive, friendship, and formal-group. Ordered logit analysis revealed that those increasing their activity participation across domains tended to perceive an improvement in their life conditions. This effect was particularly strong among older adults who became widowed, developed functional impairments, and had relatively low contact with family. The result suggested that maximizing activity participation is an adaptive strategy taken by older adults to compensate for social and physical deficits in later life.

Iwasaki (2003) in an article examined the effects of leisure coping on various stress coping outcomes including: immediate outcomes and distal or long-term outcomes, above and beyond the contributions of general coping – coping not directly associated with leisure. A repeated assessment field design was used to examine ways in which university students cope with stressors in their daily lives. The study (N=85 undergraduate students) found that leisure coping beliefs significantly predicted lower levels of mental and physical ill-health and greater levels of psychological well-being above and beyond the effects of general coping. Also, the use of leisure coping strategies (situation-specific stress coping strategies through leisure) was significantly

associated with higher levels of perceived coping effectiveness and stress reduction when the effects of general coping were taken into account. Significant contributions of specific leisure coping dimensions were found as well.

Lee and King (2003) investigated discretionary time activities among older adults, if time spent in these activities varies by gender and whether a prescribed physical activity (PA) intervention increases time spent in discretionary time PA not specifically prescribed by interventions. Study 1 compared 2 PA interventions in 103 healthy older men and women (mean age 70.2 yrs), and study 2 ocmpared a PA intervention with a nutrition intervention in 93 healthy older women (mean age 63.1 yrs). Ss in both studies completed the community health Activities Model Program for Seniors Questionnaire. At baseline, over 95% of Ss reported talking on the telephone and reading as frequent. Sedentary time activities over 80% reported visiting with friends and watching television or listening to the radio. Women engaged in significantly greater hours of social activities and household maintenance activities than did men. From baselines to 12-mo posttest, social, recreational, and household activities remained stable by gender and across time after participating in a PA intervention. Despite previously documented 2 to 3 hr increases in physical activities occurring in response to the study interventions, increases did not generalize for most Ss to activities not prescribed by their intervention.

Loy et al. (2003) explored whether leisure engagement influences the adjustment of individuals with spinal cord injury (SCI), and if so, what influence do variations in leisure activity have on adjustment to SCI. The authors also studied whether social support mediates the influence of leisure on adjustment. The model proposes that leisure engagement had a direct influence on the adjustment of individuals with SCI and that leisure engagement has an indirect influence on adjustment to SCI through the promotion of social support. 178 Ss (aged 19-76.5 yrs) participated in a 2-phase study to assess variables within the proposed model. The researchers constructed the leisure and SCI adjustment model as one possible explanations of leisure's influence on adjustment. Results from structural equation modeling confirmed that the leisure and SCI adjustment model is an "acceptable" fit to the data but leaves enough explained variance to suggest the need for further examination of alternative SCI adjustment models. Multiple regression and bivariat4e

correlations suggested that diversity, frequency and intensity of leisure engagement are associated with the adjustment of individuals with SCI.

Epstein (2003) commented on the article by Verghese et al (2003) regarding leisure activities and risk of dementia in the elderly.Verghese et al. Concluded, on the basis of their observational study, that participation in leisure activities reduced the risk of dementia. The author discussed methodological aspects of the study, including the inclusion of Ss with Alzheimer's disease, vascular dementia, or mixed dementia in the analysis. In addition, the multivariate analysis did include chronic medical illnesses, such as hypertension and cardiac disease, yet did not include previous or current smoking or hypercholesterolemia, which are important risk factors for vascular dementia.

Vinkers, Gussekloo and Westendrop (2003) commented on the article by Verghese et al (2003) regarding leisure activities and the risk of dementia in Ss older than 75 years. The authors reexamined this relation in the Leiden 85 plus study, a prospective population based study of 599 Ss at least 85 years old. All the Ss were measured for global cognitive function, cognitive need, and memory during a mean followup of 3.6 yrs. Participation was limited to Ss who did not have cognition impairment or depressive symptoms at base line. Results revealed that there was significant deterioration over time on all the cognitive tests. Cognitive leisure activities did not preserve memory. Findings indicated that the effects of a cognitive training intervention were stronger for speed and reasoning for memory.

Verghese, Kulansky and Lipton (2003) responded to the comments of Vinkers et al. (2003) and Epstein (2003) on the authors study on participation in leisure activities and the risk of dementia in the elderly. The authors commented on the study findings of Vinkers et al (2003) and Epstien's (2003) suggestions that unmeasured vascular risk factors may have influenced their results.

Dergance et al. (2003) compared ethnic differences in altitudes towards barriers and benefits of leisure time physical activity (LTPA) in sedentary elderly Mexicans (MAs) and European Americans (EAs). An in-home, cross-sectional survey was performed on 210 community dwelling elders from 10 primary care practices in south Texas that are part of the South Texas Ambulatory Research network, a

practice-based research network. Analytical variables included ethnicity, age, sex, income, education, marital status, and LTPA. Fisher exact test was used to analyze the 100 sedentary elders (LTPA <500 kcal/wk; 63 MAs and 37 EAs). It was found that self-consciousness and lack of self-discipline, interest, company, enjoyment and knowledge were found to be the predominant barriers to LTPA in both groups. Both groups held similar beliefs about benefits gained from exercise, such as improved self-esteem, mood, shape, and health, but the beliefs about the positive benefits of exercise were more prevalent in MAs. These findings remained after adjusting for age, income, education, marital status, and sex when attempting to engage elderly in LTPA, it is important not only to consider what barriers exist but also what beliefs about the benefits exist.

Crowe et al. (2003) examined whether participation in leisure activities during early and middle adulthood was associated with reduced risk of Alzheimer's disease. The sample consisted of 107 same sex twin pairs discordant for dementia and for whom information on leisure activities was self-reported more than 20 years prior to clinical evaluation. A factor analysis of these activities yielded three activity factors: intellectual cultural, self-improvement, and domestic activity. Matched-pair analyses compared activities within the discordant twin pairs while controlling for level of education. Result indicated that for the total sample, participation in a greater overall number of leisure activities was associated with lower risk of both Alzheimer's disease and dementia in general. Greater participation in intellectual cultural activities was associated with lower risk of Alzheimer's disease for women, although not for men.

Weagley and Huh (2004) examined the determinants of household expenditures on active and passive leisure by using a double-hurdel model to distinguish between the decision to purchase and the decision of expenditure. The analyzed data were the 1995 consumer expenditure survey. Retirement was a significant variable in explaining leisure expenditure and the effect varied by type of leisure expenditure. As a result, greater income elasticities for active, as compared to passive, leisure as well as for retired, as compared to near-retired, households indicate the growing importance of leisure as one enters retirement.

Van Eijck and Mommaas (2004) assessed differentiation in leisure patterns within upper middle class based on job sector (i.e., civil, servant, private sector employee, or self employed). Combining three Dutch data sets covering the 1999-2000 period (N= 3415), significant job sector differences were found for 47 of the 98 leisure items studied. The results demonstrated that leisure participation is not structured by a single, externally legitimated hierarchy ranging from highbrow to lowbrow culture, but rather by more ambiguous patterns of leisure participation based on a narrative of personal enrichment and the self. Differences between the leisure patterns of people working in different sections remained mostly stable during the 1990s.

Garcia-Martin et al. (2004) analysed the psychological effects of organized leisure activities on the elderly people that participated in them. The study was carried out with a sample of 122 people using the services of a day care center with ages ranging from 50 years to 82 years (mean 67.6 yrs). The sample was distributed into four activity groups: maintenance exercise, handicrafts, computing, and art. There was also a control group made up of people applying for these activities who were on a waiting list. A pre-post methodology was used to analyze the changes found in the following variables: social support, loneliness, life satisfaction, depression, perceived control, social self efficiency, and self perceived health. The adjustment indicators obtained partially confirmed the model they proposed. Thus, participation in these activities contributed in reducing the level of depression and loneliness in the participants and increases their level of life satisfaction, and perceived control in their lives.

Janssen (2004) examined the relationship between a leisure education program and perceptions of quality of life in older adults who reside in residential style retirement facilities in the Midwest. Through an experimental design study, for a period of six weeks, participants were able to identify how participation in a leisure education program influenced their perception in a leisure education program influenced their perceptions of quality of life based on the Quality of Life Profile: Senior Version. A mixed design analysis of variance determined that participation in the 6-week leisure education program did influence perceptions of quality of life based on the leisure sub domain component of the profile.

Bailey and McLaren (2005) tested a model incorporating physical activities performed alone and with others as predictors of sense of belonging, depression and suicide ideation. One hundred and ninety four retired adults (87 males, 107 males, mean age 68 years) completed the Yale Physical Activity Survey, the Sense of Belonging Instrument, the suicide subscale of the General health Questionnaire and the Zung Depression Inventoy. Within the context of the model, neither participating in physical activities alone, nor with atleast one other person, predicted sense of belonging, depression or suicide ideation. Having the abilities and motivation to belong was a predictor of participating in physical activities with others and actual feelings of belonging and contributed to predicting mental health in retirees. It was concluded that simply performing activities with others was not associated with a sense of belonging or mental health. Rather, sense of belonging may need to be facilitated in order for mental health to be enhanced.

Caldwell (2005) examined the empirical evidence and described theoretical perspectives that address under what conditions and why leisure can be therapeutic and contribute to health and well-being. This review of the literature provided empirical evidence that leisure can contribute to physical, social, emotional and cognitive health through prevention, coping, and transcendence. After examining this empirical evidence, the article addressed why leisure is therapeutic and concluded by presenting two concepts useful to practitioners who desire to provide leisure guidance to help people avoid risk and maximize the therapeutic possibilities of leisure.

Cassidy (2005) investigated the relationship between social, family, peer and school factors and leisure engagement within a transaction model of stress and health in 655 young adults. Results showed that the family environment, encouragement from parents and teachers, relationships with peers and socio-economic factors in childhood predict adult attitudes to and engagement in leisure. In turn, leisure attitude and engagement are related to psychological distress, optimism, perceived control and social support. It was argued that the development of patterns of leisure attitudes and engagement in childhood need to be understood in predicting and changing adult leisure behaviours relevant to health and illness.

Haworth and Lewis (2005) discussed the contested nature of work and leisure in relation to well-being, and then considered current evidence concerning the ways in which work and leisure are experienced in contemporary society. The emerging issues are then discussed drawing on two international studies which indicated the increasingly global nature of these concerns. The pervasiveness of the trend towards intensification of work, reducing time and energy for other activities, and the gendered impact of this trend and evident in both studies. As a result, many commentators have noted the negative effects of current working patterns on well-being.

Trenberth (2005) reported, while there has been a growth in leisure coping research, the debate as how leisure functions as a coping strategy and is distinguishable from more general coping strategies, that is, strategies not directly associated with leisure, continues. How leisure functions as a coping strategy and its role as a therapeutic technique with important implications for counseling was the focus of this symposium. What is clear from the articles in this issue of the British Journal of Guidance and Counselling was that there was an increasing awareness of the importance of leisure as a coping and therapeutic tool, as such these articles addressed the way and under what conditions leisure can contribute to health, well-being and work life balance. All the authors appeared in agreement with one theme. That is, if we are to fulfil our moral responsibility to those whose lives we research, then we have an obligation to continue through research and debate to develop our understanding of the role, nature and purpose of leisure and, in this way, through this knowledge, contribute to individual well-being and development.

Wemme and Rosvall (2005) investigated the association between work and non-work related stressors, respectively in relation to low leisure time physical activity (LTPA) in a general population sample. Low LTPA has been found to be strongly associated with low socio-economic status groups where psychosocial stressors have been suggested to play a mediating part. For both men and women low social participation was strongly associated with low LTPA. This is consistent with the results from other studies that supported the notion that social participation is an important determinant for health related behaviours. Stressful life situations are likely to affect a person's well-being and health related behaviours. That is to say that a bad

domestic situation may affect working life negatively and poor working conditions may affect domestic life.

Lee (2005) compared men and women regarding their household leisure time physical activity (PA), walking activity, and personal and environmental factors related to physical activity. Self-administered questionnaires were completed by 276 older adults recruited from senior centers. Findings revealed that women were less active over but more involved in household activities. The women's personal and environmental factors represented poor conditions for PA, and as result they engaged in lower levels of PA than men.

Miller and Brown (2005) explored determinants of active leisure participation through in-depth interviews with 12 heterosexual mothers of young children who were purposively sampled with contrasting levels of partner support, physical activity, and socio-economic status. The findings suggested that household norms relating to gender based time negotiation and ideologies regarding an ethnic of care were important determinants of active leisure among women with young children. A better understanding of these issues could be important in the development of strategies for promoting greater participation in physical activity among women.

Sallis and Linton (2005) described leisure researchers have long examined the many ways in which people use their leisure time and interact with leisure related resources including parks and recreation facilities. This special issue of leisure sciences shines the spot light on the specific topic of active lifestyles and the spectrum of approaches leisure researchers use to conceptualize and investigate this important area of study. They encourage the increased focus on active living by leisure researchers that is signaled by this special issue. It was found that physically inactive lifestyles are recognized as one of the most critical public health challenges of our time (U.S. Department of health and Human Services, 1996), and those working in the leisure, parks, and recreation fields have essential roles to play in contributing solutions. Public health professionals are likely to welcome both an increased emphasis on active living research and practice within leisure studies as well as increased collaboration with leisure researchers. Active living research has developed

multiple ways of supporting the development of a transdisciplinary research field, and some of these may be of interest to leisure researchers.

Adolescents often perceive aspects of their lives to be stressful, and their ability to manage stress has important health and risk behaviour consequences Hutchinson, Baldwin and Oh (2006). This study integrated recent developments in coping theory and adolescent leisure research to examine the relationship between adolescents coping goals (active/ accommodation vs. avoidance) and the types of leisure activities (structured vs. unstructured) adolescents engage in when they are stressed. A sample of adolescents (ages 12-14; N=152) was drawn from a rural middle school in the north-eastern United States. Results showed that an active accommodative coping goal orientation predicted involvement in structured leisure activities, including shared family time and activities. Counter to expectations, an active/accommodative goal orientation also predicted engagement in unstructured activities. An avoidant coping goal significantly predicted engagement in TV/music. The only structured activities to be positively predicted by an active/accommodative coping goal and negatively predicted by an avoidance coping goal were family-based activities.

Iwasaki et al. (2006) in a paper presented key findings from a multi-year qualitative study of stress and coping. A series of focus groups were conducted with diverse residents of a western Canadian city including: (a) Aboriginal individuals with diabetes, (b) individuals with disabilities, and (c) people who identified as gay or lesbian. The findings emphasized that active leisure is more than physical activity, and that less physical forms of leisure should not be undervalued in the conceptualization of active living and leisure. Coping with stress using active leisure encompassed a wide range of meanings (e.g. spiritual, social, cultural, altruistic, empowerment).

Motl et al. (2006) conducted a longitudinal study in which they examined relationship between changes in time spent watching television and playing video games with frequency of leisure-time physical activity across a 2 year period among adolescent boys and girls (N=4594). Latent growth modeling showed a reduction in time spent watching television was associated with an increase in frequency of leisure

time physical activity. Relationship was strong in magnitude and independent of sex, socio-economic status, smoking, and the value participants placed on health, appearance, and achievement. Results encouraged the design of interventions that reduce television watching as a possible means of increasing adolescent physical activity.

Iwasaki (2006) investigated stress-buffer or counteracting effects of leisure coping, by taking into account several key axes of society (i.e. gender, social class, and age) that are essential to characterize the diverse nature of our society. A 1-year prospective survey of a representative sample (n=938) from an urban Canadian city was conducted. In the total sample, long-term health protective benefits of leisure coping became evident when stress levels were higher than lower (i.e. support for buffer effects of leisure coping). However, a health protective effect of leisure coping to counteract the impact of stress on health was found substantially stronger for people with lower social class than for those with higher social class. On the other hand, health protective stress-buffer effects of leisure coping were evident regardless of people's gender and age. The findings underscore the importance of giving greater attention to the role of leisure as a means of coping with stress in health practices, particularly among marginalized groups such as individuals with lower social class.

Stress and fatigue caused by work require daily recovery periods to offset future deleterious consequences to mental and physical health. Thus Rook and Zijlstra (2006) undertook a study to gain insight into recovery processes during a normal week. The main hypotheses were that more time spent on work and work related activities will have a negative impact on recovery, while more time spent on specific leisure activities would have a beneficial impact on recovery. Using diaries, 46 respondents (average age 35) provided daily measures of fatigue, sleep and time spent on recovery activities over 7 days. Recovery activities included time spent on activities that were social, physical and work related. Results showed that whilst low effort and social activities are non beneficial to recovery, physical activities significantly predict recovery (i.e., the former increase fatigue whilst the later decrease fatigue). Sleep quality also emerges as a significant predictor of recovery. The weekend respite appears important to recovery, however the effect seems already to wane on Sunday evening in anticipation of the Monday workload.

Sabrina et al. (2007) in a study aimed to assess whether changes in leisure time physical activity over 3 years are associated with changes in health-related quality of life. The adults completed the Modifable Activity Questionnaire to assess leisure-time physical activity and the Medical Outcomes 36-item Short-Form to assess health related quality of life in 1998 and 2001. Multivariate analysis involving logistic and linear regressions determined the association between changes in leisure time physical activity and changes in health related quality of life. Results showed that over 3 years, increased leisure time physical activity was associated with high scores in health related quality of life dimensions: physical functioning, mental health, vitality for both sexes as well as social functioning for women only. An increase of 1 h per week of leisure time physical activity was associated with a 0.17 and 0.39 point increase in the vitality dimension in men and women, respectively. The mental component score was also increased in women increasing their leisure time physical activity. It was concluded that the long-term association between leisure time physical activity and health-related quality of life changes is limited and has little clinical significance, especially for men and for the physical health related quality of life dimensions. The long-term association needs to be further explored before formulating public health recommendations.

Laukkanen et al (2008) assessed the relationship of leisure-time physical activity with cancer mortality. Participants were from a population-based sample of 2560 men from Eastern Finland with no history of cancer at baseline. Physical activity was assessed using the 12-Month Leisure-Time Physical Activity Questionnaire. During an average follow-up of 16.7 years, a total of 181 cancer related death occurred. Results showed an increase of 1.2 METs (one standard deviation in metabolic equivalents) in mean intensity of leisure-time physical was related to a decrease (RR=0.85,95% CI 0.72 to 0.99) in cancer mortality mainly due to lung and gastrointestinal cancers, after adjusting for age, examination year, alcohol consumption, smoking, body mass index, and energy, fibre and fat intake. Men with leisure-time physical activity of more than 5.2 METs (highest quartile) had a lower (RR=0.63, 95% CI 0.40 to 0.99) cancer mortality compared with men whose mean intensity of physical activity was less than 3.7 METs (lowest quartile). The mean intensity of physical activity was related to the risk of cancer death among men who

exercised at least 30 minutes per day on average. It was concluded that this prospective study indicates that the mean intensity of leisure-time physical activity is inversely associated with the risk of premature death from cancer in men.

Karim and Alfred (2008) investigated relationships between physical activities in different domains (leisure time, occupational, domestic, commuting) and health indicators (self-rated health, body mass index). The short version of the International Physical Activity Questionnaire (IPAQ) and additional questions on domain specific physical activity were submitted face-to-face to 29,193 individual age 15 years and older in the 27 members states of the Europe Union, 2 affiliated nations (Croatia, Turkey), and Cyprus North in 2005 as part of Eurobarometer 64.3. Results showed that Leisure time physical activity (compared to no leisure time physical activity) was positively associated with self-rated health (males: Odds Ratio (OR) =2.85, 95% Confidence Interval (CI): 2.27, 3.58; females: OR = 2.77, 95% C.I. 2.16, 3.56) and inversely with obesity (males: OR = 0.65, 95% C.I 0.50, 0.83; females: OR=0.46, 95% C.I. 0.34, 0.63). Being in the highest quartile of the total volume of physical activity expressed using metabolic equivalents (in MET- min/week) Compared to being in the lowest quartile) was not related to self-rated health (males: OR=0.99, 95% C.I. 0.81, 1.21; females: OR= 1.19, 95% C.I.0.98,1.43) or obesity (males: OR= 1.25, 95% C.I. 0.99, 1.59; females: OR= 1.26, 95% C.I. 1.02, 1.57). Gender-specific effects were observed for other domains of physical activity. Analysis on national levels showed pronounced relationships of leisure time physical activity to health indicators. It was concluded that domains of physical activity being related to health indicators, they may pertain to surveillance.

Cornelio et al (2008) described changes in leisure time and occupational physical activity status in urban Mediterranean population-based cohort, and to evaluate socio-demographic, health-related and lifestyle correlates of such changes. Data for this study come from the Cornelle Health Interview Survey Follow-Up Study, a prospective cohort study of a representative sample (n = 2500) of the population. Participants in the analysis reported here include 1246 subjects (567 men and 679 women) who had complete data on physical activity at the 1994 baseline survey and at the 2002 follow-up. They fitted Breslow-Cox regression models to assess the association between correlates of interest and changes in physical activity.

Results showed that regarding leisure time physical activity, 61.6% of cohort members with "sedentary" habits in 1994 changed to "active" occupational physical activity. No clear correlates of change in physical activity were identified in multivariate analyses. It was concluded that while changes in physical activity are evident in this population-based cohort, no clear determinants of such changes were recognized. Further longitudinal studies including other potential individual and contextual determinants are needed to better understand determinants of changes in physical activity at the population level.

Sullyma Albarwani et al (2009) studied the effects of overweight and leisure-time activities on maximal aerobic capacity (VO_2max) in urban and rural Omani adolescents. A total of 529 (245 males, 284 females) adolescents, aged 15-16 years were randomly selected from segregated urban and rural schools. Maximal aerobic capacity was estimated using the multistage 20-meter shuttle-run test. As a result the body mass index (BMI) of urban boys and girls was significantly higher than that of rural boys and girls. Urban boys and girls spent significantly less weekly hours on sports activities and significantly more weekly hours on TV/Computer games than their rural counterpart. Urban boys and girls achieved significantly less VO_2max than rural boys and girls (44.2 and 33.0 vs. 48.3 and 38.6 ml/kg/min, respectively). Maximal aerobic capacity was negatively correlated with BMI in urban boys. It was concluded that overweight and inactivity had significant negative effects on cardiorespiratory fitness in urban boys and girls as compared to their rural counterparts.

In view of the foregoing discussion it is logical to assume that lonely persons who differ with respect to their beliefs about the causes of their loneliness may also differ with respect to their general health. More specifically it is assumed that the people who are high on loneliness scale are expected to show poorer general health as compared to those who are low on loneliness scale. One objective of the present study is to test this assumption since no such study has been undertaken till date.

Moreover as stated earlier elderly individuals who retire from their active services have no mandatory activities to perform. They may either remain idle or may engage themselves in leisure time activities. It has been shown that idle person or the

person who have no activities to perform, develops obesity which in turn may have adverse effect on their general health. Elderly people, on the other hand, who keep them engaged in leisure time activities, are likely to prevent obesity and the occurrence of negative thoughts. Hence, such individuals are likely to experience less stress and hence are likely to have better general health as compared to those elderly individuals who do not perform any leisure activity. One of the objective of the present study is to test this assumption.

Chapter III

Methodology

METHODOLOGY

In every scientific research, methodology plays a leading role. Edward (1971) believed that "in research we do not haphazardly make observation of any or all kinds but rather our attention is directed towards those observations that we believe to be relevant to the question we have previously formulated. Hence, the objective of research, as recognized by all sciences, is to use observation as a basis for answering questions of interest", which is contingent upon research methodology. Therefore, scientific precision & reliability of results in any study largely depends upon the efficacy and suitability of the strategy adopted for investigation.

Thus in carrying out any research, it is necessary to carefully adopt appropriate research design, selecting standardized tools, choosing appropriate sample through appropriate sampling techniques, undertaking sound procedures for collecting data, tabulating them and analyzing the data by running suitable statistics.

As mentioned in the preceding chapter present endeavor is aimed at studying the influence of loneliness and leisure time activities on General Health among elderly people. The main objectives of the study were (1) to investigate the impact of loneliness on general health, (2) to investigate the impact of leisure time activities on general health, (3) to find out whether or not interactional effect exist between two independent variables on dependent variable i.e., general health.

To be more specific, the study was designed to answer the following questions.

1. Do subjects experiencing high lonely and low lonely differ with respect to general health?
2. Do subjects high and low in leisure time activities differ with respect to general health?
3. Is there an interactional effect of loneliness and leisure time activities on general health?

DESIGN

A 2 x 2 factorial design in which one personality variable (loneliness) and one social variable (leisure time activities), each varying in two ways, was used in the

present study. The two values of personality variable, i.e., loneliness were (a) high lonely and (b) low lonely. The two values of social variable, i.e., leisure time activities were (a) greater number of leisure activities and (b) less number of leisure activities. Thus, there were 4 groups of subjects, namely:

1. High Lonely –High in Leisure Time Activities
2. High Lonely – Low in Leisure Time Activities
3. Low Lonely – High in Leisure Time Activities
4. Low Lonely – Low in Leisure Time Activities

There were 50 subjects in each group.

SAMPLE

In order to form above mentioned four groups of subjects, Loneliness scale (Russell, Paplau & Cutrona, 1980) and Leisure Time Activities check list (Van Willigen & Chadha, 1989) was administered on 410 subjects. The subjects whose score on Loneliness scale fell on or below 1st quartile (Q_1) were considered as Low Lonely while the subjects whose score on Loneliness scale fell on or above 3rd quartile (Q_3) were considered as High lonely. We got two groups of subjects, i.e., High Lonely & Low lonely groups. The subjects whose score on Leisure Time Activities fell on or below 1st quartile (Q_1) were considered as low in leisure time activities, while the subjects whose score on Leisure time activities fell on or above 3rd quartile (Q_3) were considered as high in leisure time activities. Hence four groups of subjects were formed and on these groups the General Health Questionnaire-28 (GHQ-28), developed by Goldberg & Williams (1988), was administered to asses the general health of the subject.

TOOLS

In the present research the following tools were used for data collection.

1. University of California Los Angeles Loneliness Scale (UCLA)
2. Leisure Time Activities
3. General Health Questionnaire-28 (GHQ-28)

University of California Los Angeles Loneliness Scale (UCLA): The UCLA Loneliness Scale developed by Russell, Paplau, and Ferguson (1978), revised by Russell, Paplau, and Cutrona (1980) to measure the magnitude of loneliness among

students. There are four alternatives to one statement, i.e., never (1), rarely (2), sometimes (3) and often (4). The subjects were asked to indicate how often they felt the way described in each of the following statements and were asked to circle one number accordingly. The UCLA is a 20-item Likert type scale in which 10 items are positively worded and 10 items are negatively worded. Positive items were scored as 1, 2, 3 and 4 while scoring for negative items were reversed i.e., 4, 3, 2 and 1. The reliability coefficient of the UCLA was calculated as ·94 by the Retest Method and the Cronbach's Alpha Reliability Coefficient of the UCLA was found to be ·96. The Parallel form Validity of the UCLA was tested with Beck Depression Inventory and correlation coefficient was found to be ·77 (Demir, 1990)

Leisure Time Activities: The checklist prepared by Van Willigen & Chadha (1989) consist of 24 items comprising 22 activities. These activities are classified under the following four categories: Cultural, Physical, Social and solitary. Respondents are asked to tick mark against activities that applies to them. Hence, the scoring done by assigning 1 to the marked items and get the total score by adding them. Higher score indicates participation in more leisure activities.

General Health Questionnaire (GHQ-28): General Health Questionnaire (GHQ-28) developed by Goldberg & Williams (1998) consists of 28 items assessing psychological symptoms. There are four subscales: (1) Anxiety and Insomnia, (2) Somatization, (3) Social Dysfunction and (4) Severe Depression, with each subscale consisting of 7 items. Each item is rated on a 4-point scale, according to how they have better experienced each GHQ item. The GHQ has demonstrated good internal consistency, high test-retest reliability and also is correlated with depression and as rated by psychiatrists with a clinical sample (Goldberg & Hillier, 1979)

There are two possible ways of scoring the GHQ:

1. A multiple-response scale or "Likert scale", where weights are assigned to each position, e.g. the response options are scored 0, 1, 2 and 3, from "less so than usual" to "much more than usual". A total score is then produced by adding together each of the scores. A higher score would indicate poorer psychological health.

2. A bimodal response scale known as "GHQ" scoring, which is a simple method of scoring and eliminates errors due to "end-users" and "middle-users". In this

method, columns 1 and 2 are both scores 0, and 3 and 4 are both scored 1. Again, scores are summed, a higher score indicating poorer psychological health.

The scoring is done by using first possible way.

PROCEDURE

First of all the two scale mentioned above were administered on large groups of elderly people selected from various localities of Aligarh to form 4 groups of subjects namely (1) High Lonely - High in Leisure Time Activities (2) High Lonely - Low in Leisure Time Activities (3) Low Lonely - High in Leisure Time Activities (4) Low Lonely - Low in Leisure Time Activities.

The General Health Questionnaire-28 (GHQ) developed by Goldberg & Williams (1988) was administered on all the four groups of subjects. As soon as the subjects finished their task, the test was collected from them and scoring was done. The data thus, obtained were tabulated group-wise and were statistically analyzed using analysis of variance to draw necessary inferences.

Chapter IV

Analysis of Data and Interpretation of Results

ANALYSIS OF DATA AND INTERPRETATION OF RESULTS

As mentioned in the preceding chapter, the present investigation was undertaken to explore the impact of loneliness and leisure time activities on general health among elderly people. In order to achieve this objective, a factorial design of experiment was employed in the present study. Two independent variables, i.e., Loneliness and leisure time activities, each varying in two ways, were used. The first personality variable i.e., loneliness, was varied in two ways by selecting (a) high lonely and (b) low lonely. The second social variable i.e., leisure time activities was also varied in two ways (a) greater number of leisure activities and (b) less number of leisure activities. Thus there were four groups of subjects namely, High lonely – high in leisure time activities, high lonely – low in leisure time activities, Low lonely – high in leisure time activities and low lonely – low in leisure time activities.

These four groups were administered general health questionnaire and scores obtained by them were tabulated group-wise. Since the main objective of the present research was to determine the influence of loneliness and leisure time activities on general health among elderly people, an analysis of variance was used to draw necessary inferences. Thus "F"-ratios were calculated for the variation of each independent variable and also for any possible interaction between two variables.

The raw scores obtained by four groups of subjects on general health questionnaire are given in Table I and their mean scores in Table II and III and F – values in Table IV.

The F-ratio for loneliness variation is 85.53 as shown in Table IV, which is significant at .01 indicating that high and low lonely groups differ with respect to general health. Disregarding the second variable i.e., leisure time activities we find in Table II that mean of the means for high lonely groups is 40.09 (i.e., 32.06 + 48.12) and the mean of the means for low lonely group is 24.44 (i.e., 18.62 + 30.26). Since the mean of the means for high lonely groups of subjects (i.e., 40.09) is markedly higher than the mean of the means for low lonely groups of subjects (i.e., 24.44), it can safely be concluded that high lonely subjects differ with respect to general health. More specifically it is established that high lonely subjects are poorer in general health than low lonely subjects.

Table I: Showing Raw scores Obtained by four groups of subjects on general health among elderly people.

S. No.	High lonely		Low lonely	
	High in leisure time activities	Low in leisure time activities	High in leisure time activities	Low in leisure time activities
1	64	38	35	16
2	58	32	17	43
3	41	40	16	38
4	56	52	17	29
5	42	53	33	12
6	39	47	40	55
7	25	47	26	30
8	14	51	8	25
9	59	67	24	30
10	15	54	18	33
11	48	34	46	17
12	32	39	39	51
13	43	46	13	26
14	15	61	10	31
15	22	51	15	33
16	50	69	28	25
17	36	45	16	51
18	25	46	9	13
19	19	40	19	47
20	21	35	21	30
21	30	61	33	49
22	36	41	7	21
23	14	50	19	31
24	11	54	2	30
25	49	44	32	14
26	17	47	11	16
27	28	30	7	41
28	32	51	19	18
29	37	32	15	22
30	30	43	23	23
31	45	58	13	9
32	24	63	5	8
33	35	48	12	13
34	14	50	13	29
35	16	59	9	12
36	15	50	35	53
37	26	52	17	34
38	34	48	3	56
39	50	59	13	47
40	36	56	17	14
41	51	52	20	56
42	25	55	23	24
43	17	59	15	26
44	27	41	9	40
45	25	38	29	34
46	11	42	13	26
47	35	48	12	56
48	27	48	18	21
49	43	45	13	18
50	39	35	24	37

F-ratio for leisure time activities is 66.99 (ref. Table IV), which is also significant at .01. The result shows that high in leisure time activities and low in leisure time activities subjects differ with respect to general health. Ignoring loneliness, it is found in Table 3 that mean of the means for high in leisure time activities is 25.34 and the mean of the means for low in leisure time activities groups of subjects is 39.19. Since the mean of the means of high in leisure time activities subjects (i.e., 25.34) is lower than the mean of the means for low in leisure time activities subjects (i.e., 39.19), it is can safely be concluded that high in leisure time activities subjects differ with respect to general health. More specifically it is established that high in leisure time activities subjects are better in general health than low in leisure time activities subjects.

Table II : Showing mean of the means of subjects under high lonely and low lonely conditions.

Groups	High in leisure Time activities	Low in leisure Time activities	Mean of the means
High lonely	32.06	48.12	40.09
Low lonely	18.62	30.26	24.44

Table III : Showing mean of the means of subjects under high in leisure time activities and low in leisure time activities conditions.

Groups	High lonely	Low lonely	Mean of the means
High in leisure Time activities	32.06	18.62	25.34
Low in Leisure Time activities	48.12	30.26	39.19

Table IV : Showing F - ratios

Source of variation	df	Sum of squares	Mean of squares	F-ratio
Loneliness	1	12246.12	12246.12	85.53
Leisure time activities	1	9591.12	9591.12	66.99
Loneliness x Leisure time activities	1	122.10	122.10	0.85
Within	196	28061.50	143.17	
Total	199	50142.95		

Table V : Showing mean of scores on general health obtained by High lonely – High in leisure time activities, Low lonely – High in leisure time activities, High lonely – Low in leisure time activities and Low lonely – Low in leisure time activities subjects.

Conditions	High in leisure Time activities	Low in leisure Time activities	Difference
High lonely	32.06	48.12	16.06
Low lonely	18.62	30.26	11.64
Difference	13.44	17.86	

F-ratio for interaction between loneliness and leisure time activities, as shown in Table IV is 0.85 which is insignificant. The result suggests that there is no interactional effect between loneliness and leisure time activities on general health among elderly people. As shown in Fig.1.0. the two values of loneliness (i.e., high lonely and low lonely) are shown on the horizontal axis. The data points represent

means of the 4 conditions: Point 1 is the mean for high lonely and high in leisure time activities group; Point 2 is the mean for high lonely and low in leisure time activities group; Point 3 is the mean for low lonely and high in leisure time activities group; and Point 4 is the mean for the low lonely and low in leisure time activities group. The line that connects point 1 and 3 represents the mean of general health scores of high in leisure time activities subjects, half of them were high lonely and the other half low lonely subjects. The line that connects point 2 and 4 represents the mean of general health scores of low in leisure time activities subjects, half of them were high lonely and the remaining half were low lonely subjects. Since these two lines are almost parallel, it is concluded that there is no interactional effect between loneliness and leisure time activities on the general health among elderly people. The same conclusion may also be drawn by turning our attention to Table V. In Table V we find we find that the difference between high lonely high in leisure time activities group and low lonely high in leisure time activities group is 13.44 which is not different enough than the difference between high lonely low in leisure time activities group and low lonely low in leisure time activities group (i.e., 17.86) to make the interactional effect significant. The same results are found when the differences in other directions are compared, i.e., the difference between high lonely high in leisure time activities group and high lonely low in leisure time activities group is 16.06 (ref. Table V) whereas the difference between low lonely high in leisure time activities group and low lonely low in leisure time activities is 11.64 (ref. Table V). These results clearly indicate the non existence of an interactional effect between loneliness and leisure time activities on general health among elderly people.

Loneliness x Leisure Time Activities

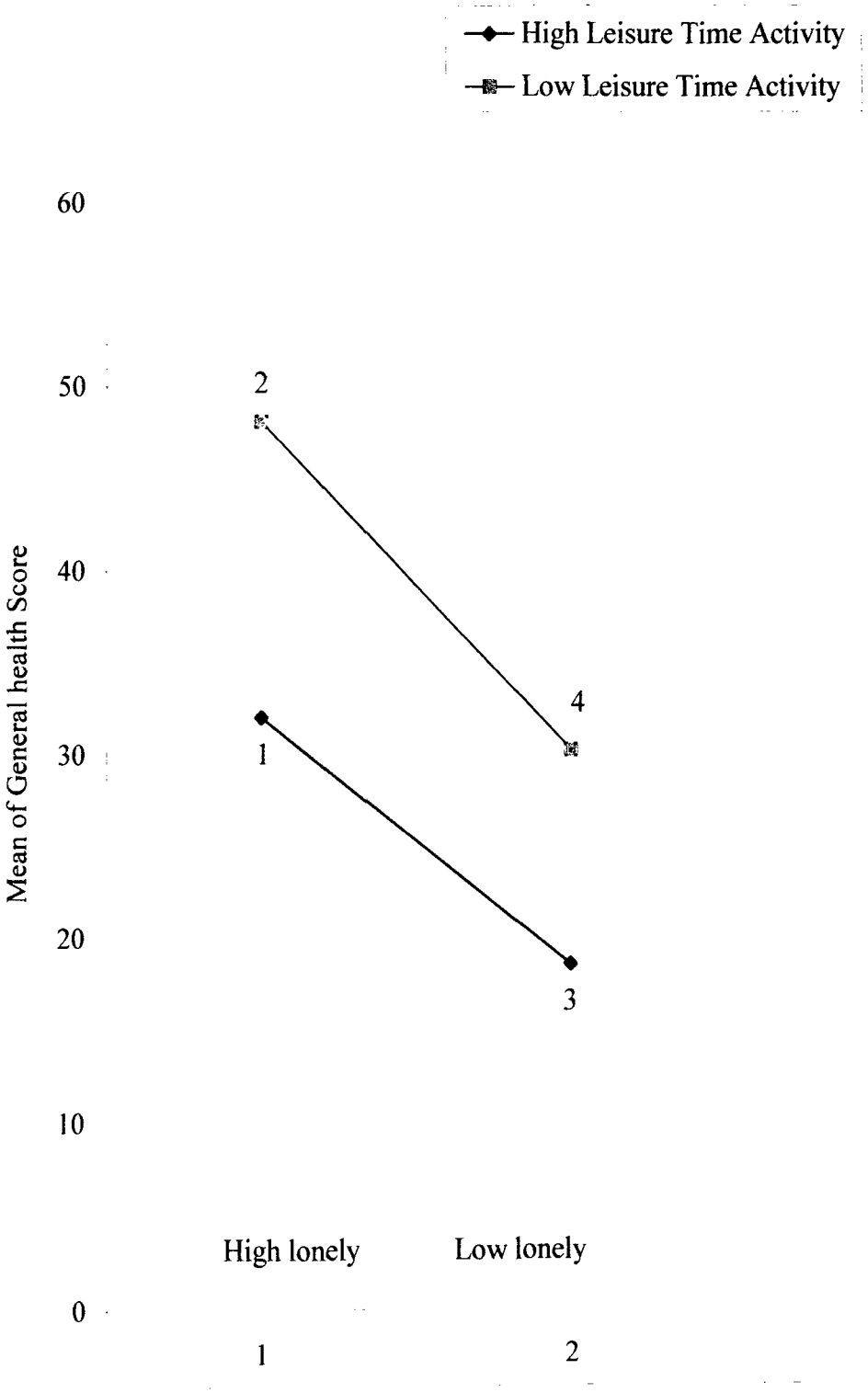

Figure 1.0

Chapter V

Discussion and Conclusions

DISCUSSION AND CONCLUSIONS

As mentioned in the preceding chapters, the present study was undertaken to examine the impact of loneliness and leisure time activities on general health among elderly people. The main findings of the study are:

(1) Lonely subjects have poorer general health than non-lonely subjects.

(2) Subjects who participate in leisure time activities show better general health than those subjects who do not participate in leisure time activities.

(3) There is no interactional effect of loneliness and leisure time activities on general health.

The first finding of the present research, i.e., lonely subjects show significantly poorer general health as compare to non-lonely subjects, is consistent with the findings obtained by numerous researchers who have also demonstrated that lonely subjects develop feelings of depression, anxiety, unhappiness, dissatisfaction associated with pessimism, self blame and Shyness (Anderson et al., 1994; Jackson, Soderlind and Weiss, 2000; Jones, Carpenter and Quintana, 1985; Cristensen and Kashy, 1998; Jones et al., 1983). Needless to say any person who develop the above mentioned symptoms cannot be categorized as having good general health. Moreover, other studies have shown a correlation between increased loneliness and a variety of physical deficits such as low vision (Holmen, Andersson, Ericsson, Rydberg and Winblad, 1994; Baron, Foxall, Dollen, Shull and Jones, 1992, 1994), reduced hearing (Cohen, 1994, Holmen, Andersson, Ericsson, Rydberg and Winblad, 1992) and deficit in cognitive functioning as measured by Minimenntal State Examination (Holmen, Andersson, Ericsson, Rydberg and Winblad, 1992, 1993). Similarly Svanborg (1977) showed that loneliness results in more medical examinations and Green et al. (1992) found that loneliness is one of the three main factors leading to depression and societ. Karen Kaasa (1998) observed that there is more loneliness among respondents who report having poor health. All these findings are in agreement with first finding of our investigation.

It is an open secret that healthy individuals find pleasure in leisure time activities, go for a walk, read, go to pubs and coffee shop and attend club for retired

people. Such individuals are not only healthy but also are not lonely, hence they find pleasure in performing these activities. Lonley persons, on the other hand, have no pleasure in performing these activities resulting into poor health. In short feeling of loneliness leads to disinterest in leisure time activities, in walking, reading and in attending clubs which inturn leads to poor health. Such a feeling of loneliness was considered so crucial that IMSERSO (Institute for Older Person and Social Services) in collaboration of UNECE (United Nations Economic Commission for Europe) and UNFPA (United Nations Population Fund) undertook two complementary studies (2000) to takle this issue. The first finding of our research to highlighted the seriousness of loneliness and its impact on general health.

Another potential explanation of our finding is that individuals, who experience loneliness, are constantly under severe stress. This continuous state of stress may contribute in the development of minor illness like cold and fever as well as fatal illness like cardiovascular disease and cancer (Kiecolt-Glaser and Glaser, 1992; Frese, 1985) by interfering with efficient operation of immune system. Researches have demonstrated that stressors including disruptions in interpersonal relationships, loneliness, academic pressure, daily hassles and lack of social support impairs immune system resulting into various ailments (Cohen et al., 1992; Miller et al., 1999). Our finding provides empirical evidence to these contentions by demonstrating that lonely people have poorer health as compare to non-lonely persons.

Still another possible explanation of our first finding is that loneliness is a great source of anxiety. Lonely persons always remain anxious and worried. Anxiety and worries are potent determiners of poor health (Anderson et al, 1994; Jackson, Soderlind and Weiss, 2000). Thus loneliness brings out anxiety which inturn deteriorates the health of the individual. The finding under discussion provide empirical support to this notion.

Moreover, the mind of the lonely person is a room for devils. A lonely person always remains busy in negative and self destructing thinking. It is one of the reason why lonely persons develop societal tendencies. Such a life style is bound to have adverse effect on general health of the individuals. The first finding of our research has demonstrated this fact.

In their stimulating article Routasalo and Pitkala (2003) have cited several studies showing positive correlation between loneliness and impairment of physical functioning (Sugisawa, Liang and Liu, 1994; Berkman and Syme, 1979; Jylha and Aro, 1989; Olsen, Olsen, Gunnar Svensson and Walstrom, 1991) and positive correlation between loneliness and use of health services (Ellaway, Wood, Macintyre, 1999; Geller, Janson, McGovren and Valdini, 1999). Moreover, Routasalo and Pitkala (2003) observed that loneliness is common among elderly people who suffer from depression, negative feelings, have poor quality of life, increased mortality and have increased need for social and health care services. All these findings are in total agreement with the first finding of our research.

Further support to our finding comes from recent study undertaken by Bhatia, Swami, Thakur and Bhatia (2007) who found that out of 361 aged person of Chandigarh, 311 (i.e., 86.1%) persons reported one or more health-related complaints, with an average of two illness.

The idea that a satisfying balance of work, relationship, and leisure time activities will lead to a more rewarding and healthy life was supported by the second finding of our research, which has found that subjects who remain engaged in leisure time activities have better general health than those subjects who do not perform leisure time activities. This finding of our research is in agreement with the findings obtained by other researchers. For instance, Pearson (1998) found job satisfaction and leisure satisfaction are significant predictors of psychological health. Similarly, Caldwell, Smith and Weissinger (1992) reported that subjects who participate at high levels in a variety of leisure activities show higher rates of perceived physical, mental and social health than those subjects who are less involved. More or less similar findings were obtained by Dupuis and Smale (1995) who found that adult of 55 age and older who regularly participate in a variety of leisure activities exhibit better psychological well-being and less depression.

Though the second finding clearly reveals that subjects who remain engaged in leisure time activities show better general health than those who do not engage in such activities. The pertinent question is how leisure time activities help in maintaining good health. One possible answer to this question is that leisure time activities is one of the most effective strategy to cope with stress (Kleiber, Hutchinson and Williams,

2002; Kimball and Freysinger, 2003; Klitzing, 2003; Bowleg et al., 2003; Shields, 2003). It has been established beyond doubt that reduction or elimination of stress improve general health of the individual. Another possible answer is that leisure time activities (physical or non-physical) are undeniably a core component in active living and has been linked to many beneficial outcomes. Such as improved health (Tudor and Bassett, 2004; Brach, Simonsick, Kritchevsky, Yaffe and Newman, 2004; Janisse, Nedd, and Nies, 2004; Brown et al., 2004; Gregg et al., 2003).

One of the most potential explanation of the second finding of our research lies in the fact that activities are important for aging. Participation in leisure time activities by older adults have been found beneficial in improving quality of life and health (Katz, 2000). Menec (2003) and Lennartsson and Silverstein (2001) found that active engagement in social and productive activity predict outcomes like greater happiness, better functioning and reduced mortality whereas solitary activity such as handwork and hobbies predict happiness but had no effect on mortality. The second finding of the present research is also in consonance with these findings since it asserts that participation in leisure time activities improves general health. Similar findings were recently obtained by Gautam, Saito and Kai (2007) who found that activities in late life have positive effects on the mental health of the older adults. They further observed that saying prayers, watching television, listening to the radio, and participating in physical exercise correlated to lower levels of depression.

Another possible explanation of the second finding is that participating in leisure time activities gives greater meaning one's life contributes in the enhancement of quality of life, helps in personal growth, self expression, increased learning opportunities, satisfies needs not met in one's non-leisure time. All these outcomes of leisure time activities are predictors of good health. Hence, second finding of our research demonstrated that those older adults who participate in leisure time activities show better general health than those who do not participate in leisure time activities. Most recently, Mozaffarian, Furberg, Psaty and Siscovick (2009) strengthened our finding by demonstrating that light to moderate leisure time activities including gardening, outside chores, Golfing, dancing, walking are linked with a significantly lower risk of developing atrial fibrillation (AF).

Still another possible explanation of second finding of our study is that lack of leisure time activities inculcate feelings of worthlessness, boredom, meaninglessness in life, essence of loneliness and hopelessness. Moreover, cognitive functioning is adversely affected by lack of leisure time activities. Consequently the health deteriorate, for all these symptoms are strong predictors of poor health.

The last finding of the present research i.e., no interaction exist between loneliness and leisure time activities on general health, indicates that general health scores are independent of loneliness and leisure time activities.

The overall findings of the present research not only open new dimensions in the area of health psychology but also highlight the predictors of good health. More specifically, the findings of the present research establish beyond doubt that loneliness and lack of leisure time activities specially in old age is serious threat to general health. It is, therefore, strongly recommended that old people should not be left alone and they should be encouraged to participate in leisure time activities – they should be provided all possible facilities for such activities which they can perform during free time. By implementing this recommendation, older people would be able to maintain sound health and live longer. Thus family members are advised that they should not leave their old parents or grandfather and grand mother alone and provide best possible opportunities for making them indulge in leisure time activities. Unfortunately busy life and opting for nuclear family make the lives of older people extremely pathetic and miserable. No one has time to look after them consequently they become helpless lot and need their end in a highly tragic way. The findings of the present research should serve as eye opener for such families, for young members of the family would also become old one day like their fathers or grandfathers and they may be paid in the same coin.

Summary

SUMMARY

Health is a common theme in most cultures. Infact, all communities have their concepts of health as part of their culture. In some cultures health and harmony are considered equivalent; harmony being defined as "being at peace with self, the community, god and cosmos". The ancient Greeks and Indians shared this concept and attributed disease to disturbance in bodily equilibrium of what they called "humors".

Historically, the term 'health' is derived from an old Anglo-Saxon word 'haelth', meaning the conditions of being safe and sound, or whole. However this historical definition was lost because of the common belief that health was in essence freedom from disease.

"Health" is one of those terms which most people find it difficult to define although they are confident of its meaning. Therefore, many definitions of health have been offered from time to time, including the following:

Webster said that "the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain".

"Soundness of body or mind; that condition in which its function are duly and efficiently discharged" (Oxford English dictionary)

"a condition or quality of the human organism expressing the adequate functioning of the organism in given conditions, genetic and environment".

The widely accepted definition of health is that given by the World Health Organization (1948) in the preamble to its constitution, which is as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The WHO definition goes beyond the mere absence of disease. It envisages three dimensions or components of health — Physical, mental, and social all closely related. A fourth dimension has also been suggested, namely, spiritual health.

The definition of the WHO is still extensively quoted, although the organization has developed its view considerably since that time. This historic definition has also been heavily criticized, mainly on two grounds. One is that it is

totally unrealistic and idealistic (how often does anyone truly feel in a state of 'complete physical, mental, and social wellbeing?) The other criticism is that it implies a static position, whereas life and living are anything but static. The idea that health means having ability to adapt continually to constantly changing demands, expectations and stimuli can be seen to be preferable.

DIMENSIONS OF HEALTH

The above discussion and an analysis of the foregoing two definitions inevitably lead one to conclusion that the concept of health is multidimensional. These dimensions are as follows:

(a) Physical Dimension

This is Perhaps the most obvious dimension of health and is concerned with the mechanistic functioning of the body. It conceptualizes health biologically as a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body. The signs of physical health in an individual are: "a good complexion, a clean skin, bright eyes, lustrous hair with a body well clothed with firm flesh, a sweet breath, a good appetite, sound sleep, regular activity of bowels and bladder and smooth, easy, coordinated bodily movements. All the organs of the body are of unexceptional size and function normally; all the special senses are intact.

Evaluation of Physical Health:

According to modern medicine various tools and techniques are used in various combinations for the assessment of physical health. These are as follows:-

- Self assessment of overall health
- Inquiry into symptoms of ill health and risk factors
- inquiry into medications
- inquiry into levels of activity (e.g., number of days of restricted activity within a specified time, degree of fitness)
- inquiry into the use of medical services (e.g., the number of visits to a physician number of hospitalizations) in the recent past
- standardized questionnaires for cardiovascular diseases
- standard questionnaires for respiratory diseases clinical examinations

- nutrition and dietary assessment
- biochemical and laboratory investigations

At the community level, the state of health may be assessed by such indicators as death rate, infant mortality rate and expectation of life. Ideally, each piece of information should be individually useful and when combined should permit a more complete health profile of individuals and communities.

(b) Mental Dimension

Mental health is not mere absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose.

Mental and physical health are inter-related. The ancient concept, a sound mind in a sound body has been rehabilated. Poor mental health affects physical health and vice versa. Psychological factors are considered to play a major role in disorders such as hypertension, peptic ulcer and asthma. Some major mental illnesses such as depression, and schizophrenia have both psychological and biological components.

Some characters of Mentally Healthy Person pointed out by psychologists are:

a. a mentally healthy person is free from internal conflicts; he is not at "war" with himself.

b. He is well-adjusted, i.e., he is able to get along well with others. He accepts criticism and is not easily upset.

c. He searches for identity.

d. He has a strong sense of self-esteem.

e. He knows himself: his needs, problems and goals (this is known as self-actualization).

f. He has good self-control-balances rationality and emotionality.

g. He faces problems and tries to solve them intelligently, i.e., coping with stress and anxiety.

Assessment of mental health at the population level may be made by administering mental status questionnaires by trained interviewers.

(c) Social Dimension

Health cannot be isolated from social and cultural context. A person's health is inextricably related to everything surrounding him. It is an established fact that it is not possible to raise the level of a people's health without changing their social and cultural environments. For example, people obviously cannot be healthy if they cannot afford necessities of food, clothing and shelter, nor can they be healthy in countries of extreme political oppression where basic human rights are denied. Women cannot be healthy when their contribution to society is undervalued, neither blacks nor whites can be healthy in a racist society where racism undermines human worth, self esteem and social relationships. Unemployed people cannot be healthy in a society which only values people in paid employment, and it is very unlikely that anyone can be healthy in an area which lacks basic services and facilities such as health care, transport and recreation. Michael Wilson puts this graphically when he says that health cannot be possessed, "It can only be shared. There is no health for me without my brother. There is no health for Britain without Bangladesh". Thus social health takes into account that every individual is a part of a family and of wider community and focuses on social and economic conditions and well-being of the "whole person" in the context of his social network.

(d) Spiritual dimension

This is the ability to establish peace and harmony in our lives. Being spiritually healthy does not mean that person have to be religious. Some find their spiritually through nature, meditation, reciting affirmations or yoga. This for some people is connected with religious beliefs and practices; for others it is to do with personal creeds, principles of behavior and ways of achieving peace of mind and being at peace with oneself. It is the intangible something that transcends physiology and psychology. Plato lamented: "For this is the error of our day that physicians separate the body from soul". This is even true today. The importance of this aspect of health can hardly be overemphasized.

(e) Emotional Dimension

It is the ability to understand ourselves and cope with life's challenges. It is our emotional reaction to life. This dimension of focuses on acknowledgment of

feelings such as anger, fear, hope, love and happiness. Optimists have strong emotional health compared with pessimists.

Historically the mental and emotional dimensions have been seen as one element or as two closely related elements. However, as more research becomes available a definite difference is emerging. Mental health can be seen as "knowing" or cognition while emotional health relate to "feeling".

(f) Vocational Dimension Vocational health is one's attitude about work and career. This dimension involves preparing for and participating in work that provides personal satisfaction and life enrichment. This includes continued development of occupational skills, finding balance between work and leisure activities, and finding challenging work.

The importance of this dimension is exposed when individuals suddenly lose their jobs or faced with mandatory retirement. For many individuals, the vocational dimension may be merely a source of income. To others, this dimension represents the culmination of the efforts of other dimensions as they function together to produce what the individual consider life "success".

DETERMINANTS OF HEALTH

In the past three decades, basic and applied research across a range of substantive areas has affirmed the value of the biopsychosocial perspective and demonstrated how biological, psychological and social processes operate together to affect physical health outcomes (Baum & Posluszny, 1999; Cohen, 1998; Salovey, Rothman & Rodin, 1998; Taylor, Repetti & Seeman, 1997). Beside biopsychosocial variables, macro variables e.g., age, gender, income, education are also included in the multiple systems.

(a) Biological

To represent the biological cluster of health, several variables were also tested in the studies, e.g., self-reported health, that is, physical health and functioning. As this has been found to be correlated with objective measure of health, such as, physicians' assessment (Blazer & Houpt, 1979; Mossey & Shaprio, 1982; Idler & Angel, 1990; Szaflarski & Cubbins, 2004). IN case of ill health, information on acute and chronic condition were also obtained along with reporting of family linkage

endorsement. Physical/Somatic symptoms and complaints and psychological distress were also taken into account.

Body mass index, blood pressure, blood sugar, hemoglobin level, blood grouping, pulse rate and skin temperature were also included. These variables are important not only to study health behaviour but also for interventions, such as losing weight and exercise when blood pressure is elevated. Advice regarding food and nutrition can help in case of poor hemoglobin level and abnormal lipid profiles. The way people think about health and wellness too influence their health and wellness behaviour (Hughner & Kline, 2004; Lawton, 2003).

Proper physical and psychological functioning is also considered to be indicator of being healthy (Mc Kague & Verhoef, 2003).

(b) Psychological

Among the psychological factors, recent researches show a major change of focus from negative to positive factors. Hope and optimism are the positive conditions of human strength which include the positive cognitive, emotional and motivational states. In the past two decades, research has shown that optimism, in face of crisis, make people expect good things to happen and achieve better outcome (Scheier, Carver and Bridges, 2000). Optimism may promote longevity, Physical well-being and health promoting behaviour (Peterson, 2000; Peterson, Seligman, Yurko, Martin & Friedman, 1998; Scheier & Carver, 1992).

Peterson (2000) has suggested that religious thought could nurture certain aspects of optimism especially as a known specific positive expectation (Tiger, 1979) because such aspect of expectation promote general state of vigour and resilience which may lead to desirable outcome in face of drastic condition, such as, illness. Psychologists studying faith phenomenon have also suggested that faith offers a sense of meaning and purpose (Hood et. Al., 1996), enhances long range hope and generates optimism for near future (Myer, 1992). Sethi and Sligman (1993) reported a positive relationship between religiosity (even fundamentalism), optimism and hope (Ai,. Peterson & Huang, 2003; Ai et al., 2004).

(c) Social

A growing array of environmental and personality characteristics have been identified in epidemiological research as risk factors for physical illness and premature death. For example, individuals who are socially isolated or report low level of social support are at increased risk of cardiovascular disease, cancer, and premature death (House, Landis & Umberson, 1988). High level of job stress also place people at gender risk of illness (Schnall, Landsbergis & Beker, 1994), as does the chronic stress of caring for seriously ill family members (Schulz & Beach, 1999). Individuals who are prone to anger and hostility are at increased risk of developing cardiovascular disease and premature death, as are people who report symptoms of anxiety, depression, pessimism and hopelessness (Smith & Gallo, 2001).

People who are socially isolated, experiencing high level of job stress, or are prone to negative emotions may be likely to smoke more, overeat, consume too much alcohol, or avoid regular exercise. These health behaviours could account for some of the effects of the social environment and personality on health. However, the association of these psycho-social risk factors with subsequent morbidity and mortality remains significant even when the effects of health behaviour are controlled (Adler & Mathews, 1994). The prevailing view in this research area is that psychological effect of stressful environment and negative emotions are the link between psychological risk factors and subsequent disease. These mechanisms are best understood in two general pathways __ the effect of stress on cardiovascular system and its effect on immune system (Rozanski, Blumenthal & Kaplan, 1999).

Psychosocial factors identified in epidemiological studies as risk factor for cardiovascular disease tend to be related to psycho-physiological mechanism. For example, social support generally reduced the magnitude of stress induced physiological reactivity (Uchino, et.al. 1996), and personality characteristics associated with increased risk of cardiovascular disease such as hostility. These are associated with more pronounced cardiovascular and neuro-endocrine reactivity (Smith & Gallo, 2004)

The third major aspect in health psychology involves the impact of psychosocial aspects and interventions on acute and chronic medical illness such as pain, disability, emotional distress, and the usefulness of psychological interventions.

Psychological interventions facilitate to cope with chronic disease (e.g., arthritis, headache and chronic back pain) and stress, and aim to improve health.

(d) Environmental

Environmental threats and demands evoke transient increase in heart rate, blood pressure, and concentration on various hormones (e.g. epinephrine, nor-epinephrine, cortisol, etc.). In human and animal research, over a period of time, these stress induced physiological changes appear to promote more enduring levels of high blood pressure: , initiate and hasten the development of atherosclerosis in the coronary and carotid arteries. Atherosclerosis in these sites increases the risk of coronary heart disease and stoke respectively. Environmental stresses and the brief psychogenic changes they evoke can also precipitate acute manifestation of cardiovascular disease (e.g., temporary reduction of oxygen supply to heart muscle) among individuals with pre-existing atherosclerosis (Rozanski, et.al.1999).

(e) Ways of Living

Health is a way of life. It is related deeply to life style which includes ways of living, personal hygiene, habits and behviour. These life activities are the experiences engaged in by the individual. These experiences determine the way he lives, which to a large extent produce the quality of life and the degree of effective living. Experiences can be classified as physical, mental, social and spiritual. They include what the individual does each day__ his work, his play, his sleep and rest, his expression of faith __ all his health practices determining his way of living. The selection of wholesome experiences and adoption of a balanced program of activities will surely exert a powerful influence on the quality of life and consequently ensure good of health.

Currently, the major health problems in the developed countries are tied significantly to life style, viz., cardio-vascular disease, automobile accidents, drug and alcohol abuse, suicides and homicides. In order to change for the better it will require education to change life style and behavioural pattern. Fruedenberg (1978) suggested a strategy called "Health Education for Social change".

(f) Socio-economic Conditions

Socio-economic conditions have long been known to influence human health. The health of a community is integrally related to its economic status and its social

and political organization. The world today is divided into rich and poor, developed and undeveloped, haves and haves-not. There is little doubt that in many developed countries, it is the economic progress that has been a major factor in reducing morbidity, increasing life expectancy and improving quality of life.

It is said that poverty leads to sickness and sickness to poverty, one of the mankinds' vicious cycle. The teeming millions of india's population, which has now crossed the one billion mark, live in rural areas in abject poverty. They are infact below the poverty line. The striking features of the rural life of our country are insanitary living conditions, malnutrition, lack of safe drinking water__ all responsible for poor health. It is an established epidemiological finding that the prevalence and distribution of disease is strongly influenced by economic factors. Infact, most of the infectious and nutritional deficiency diseases, common in developing countries, are really "diseases of poverty". Poverty disposes to high maternal, child and infant mortality rates. Poverty also predisposes to crime, violence, drug abuse, depression, and other forms of deviant behaviour.

The very state of being employed in productive work promotes health, because the unemployed usually show a higher incidence of ill health and death.

Ironically, affluence may also be a contributory cause of illness as exemplified by a high rate of coronary heart disease, diabetes in the upper socio-economic groups. The major medical causes of death in the west today are cardiovascular disease and cancer which together accounts for two-thirds of all deaths.

Health is also related to the country's political system. Often the main obstacles to the implementation of health technologies are not technical, but rather political. If poor health patterns are to be changed, then changes must be made in the entire sociopolitical system in any given community.

(g) Health Services

Health services include all those personal and community services including medical care, which are directed towards the protection and promotion of the health in the community. They range from preventive to curative measures, including health guidance, periodical health examinations, recording of health histories, and clinical, surgical and hospital care. The purpose of health services is to improve the health

status of population. For example, immunization of children will have a powerful impact on the incidence and prevalence of particular diseases. Provision of safe water can prevent mortality and morbidity from water-borne diseases. The care of pregnant women and children would contribute to the reduction of maternal and child morbidity and mortality. The importance of all these services can hardly be over-emphasized in ensuring good health of the community.

The World Health Organization has taken a leading role in action for health promotion in the 1980s and 90s. WHO stated in 1977, at the 30th World Health Assembly that the main social target of governments and WHO in the coming decades should be the attainment of all citizens of the world by the year 2000 of a level that will permit them to lead a socially and economically productive life. This was the beginning which has come to be known as the "health for all" movement which led to the development of regional strategies for different regions of the world in 1980s.

The regional strategy called for fundamental changes in the health policy of member countries, including a much higher priority for health promotion and disease prevention. It is known for not merely the health services but all public sectors with a potential impact on health to take positive steps to maintain and improve it. Specific regional targets were set and published in 1985. This gave impetus to the new interest in health promotion activities during the 1990s with emphasis on addressing inequalities in health through attention to the key social, economic and environmental determinants of ill-health and on community participation in health promotion. These moves are all positive indicators of a concern to address inequalities in health and deal with root causes of ill-health in today's society.

MODELS OF HEALTH

Health Belief Model

This was developed by four psychologists' – Hochbaum, Kegeles, Leventhal and Rosenstock (Rosenstock, 1974) to predict individuals' preventive health behavior. It was later on modified by becker and maiman (1975) incorporated sick-role behavior and compliance with medical regimens. Readiness to take action and engage in health related behavior depends on a number of factors. The first two are concerned with the extent to which individuals feel vulnerable to a particular illness. This involves whether they feel susceptible to contracting the illness and their

thoughts about how severe it is. Besides, susceptibility, severity, and vulnerability and other factors involved in the model are benefits (potential to be gained from a particular course of action), barriers (degrees of physical, psychological or financial distress associated with any form of action) and cues to action (stimuli that trigger appropriate health behavior). Various factors such as demographic, ethnic, social; and personality traits may also influence health behaviour.

Locus of Control Model

Rotter (1954) proposed that behavior was a function of the individual's belief that the behavior will lead to reinforcement (expectancy) and how much that reinforcement is liked (reinforcement value). The significant factor in determining generalized expectancies is locus of control. To measure these generalized expectancies, almost a dozen different locus of control measures have been developed (Lefcourt, 1982), but the test that Rotter devised is known as the I-E Scale.

We have an external locus of control if we believe that we are not masters of our own fate and are subject to the control of outside forces, such as luck or destiny (e.g., such beliefs that many people can be described as victims of fate; most of the things that happen to us are a matter of luck). However, we have an internal locus of control if we believe that we have ability to influence and determine the features that affect our lives (e.g., beliefs such as __ What happens to other people is very much of their own making; we are in complete control of our own destiny).If we have an external locus of control, we are less likely to engage in behaviors that could have a positive effect on our health or lives, believing that it does not matter what we do, fate has already decided for us. But if, on other hand, we have an internal locus of control, then we are much more likely to do things for ourselves because we believe that we can have a significant say in how our life is run.

Conflict Theory Model

This is a model of personal decision making that attempts to specify the conditions under which individuals will give priority to avoiding subjective discomfort at the cost endangering their lives, and under what conditions they will make a more sensible decision by seeking out and taking into consideration the available medical information about the real consequences of alternative courses of

action in order to maximize their chances of survival Janis (1984). Janis and Mann (1977) have proposed five different patterns of coping with realistic threats and five stages that individual go through in order to arrive at a firm decision. These five coping patterns of the decision are described below:-

1. Unconflicted Persistence: Ignoring the information about risks, the person continues to behave in a complacent fashion.
2. Uncomplicated Change: Accepting without question and adopting whatever course of action is recommended.
3. Defensive Avoidance: Evading the issue by putting things off, shifting the responsibility to someone else or selectively attending to the sorts of information one wants.
4. Hyper Vigilance: Due to a feeling of impending doom the person becomes so panicky that he jumps at the first solution that appears to provide the answer, without considering the other courses of action.
5. Vigilance: The individual carefully considers all the course of action in an unbiased manner before taking a decision for good reason.

Loneliness is an emotional and cognitive reaction to having fewer and less satisfying relationships than one desires (Archibald, Bartholomen & Marx, 1995; Peplau & Perlman, 1982). In Understanding loneliness, keep in mind that it is a subjective experience, reflecting what we feel and think about our interpersonal life, and it is not the same thing as solitude or being alone. We can spend long periods of time alone without feeling lonely, and we can also feel terribly lonely in a crowd. The partners in a long marriage can experience loneliness, whereas a recently widowed person may not feel lonely (Tornstam, 1992). Infact, research has shown that lonely and nonlonely people do not differ in the quantity of their social interaction, but rather in the quality of such exchanges. Lonely people spend more time with strangers and acquaintances and less time with friends and family than those who are not lonely (Jones et.al., 1985). Loneliness is the inability to maintain the level of affiliation one desires. Loneliness is more than a feeling of wanting company or wanting to do something with another person. Loneliness is a feeling of being cut off, disconnected and alienated from other people. The lonely person may find it difficult or even

impossible to have any form of meaningful human contact. Lonely people often experience a subjective sense of inner emptiness or hollowness, with feeling of separation or isolation from the world.

DEFINITIONS OF LONELINESS

Different researchers have given different definitions of loneliness. Following are some examples:

Loneliness is "an estrangement from oneself and from others, a feeling of alienation, even in the midst of others" (J.de Jong-Gierveld and J. Raodschelders)

Loneliness is "an incredible intensity and pain that obliterates the memory of past relationships and spills over into the future" (S. Gordon)

Loneliness is "a barrier that prevents one from uniting with the innerself" (C. Rogers)

Loneliness is an "unpleasant, painful, anxious yearning for another person" (J. J. Ponzetti)

Loneliness is "the absence of an adequate positive relationships to persons, places or things" (Brage and Meredith)

K.Rook defined "Loneliness as an enduring condition of emotional distress that arises when a person feels estranged from, misunderstood or rejected by others and/or lacks appropriate social partners for desired activities, particularly activities that provide a sense of social integration and opportunities for emotional intimacy".

According to Vicki "Loneliness is a feeling that no one wants you and frustatating because you don't know why?

Jasmine defined "Being in a place or situation and yet being totally detached from it. And there is this huge yawning space inside you crying out to you".

Loneliness is the "Ultimate form of poverty" (Hans Koresh)

According to William "Loneliness is a living death".

Peter says that "loneliness is a sharp and cold claw that squeezes your heart with amazing strength; and when it's shattered into pieces, and every single part of your body weights like tons of lead, people see in you nothing but a sleepy face, not

caring on going deeper into your state... they don't even want to know you're feeling like hell..."

Similar to social anxiety, we can conceive loneliness as both a short-lived state and a chronic, long-term trait. For example, when a student first arrives on campus as a fresher, he may experience a temporary sense of loneliness until he becomes integrated into the college community. In contrast, some people suffer from chronic loneliness, regardless of the length of time spent spend becoming acclimated to new social settings. Although loneliness is a subjective experience, social psychologists have developed objective measures to identify lonely people. One of the more commonly used measures is the UCLA Loneliness Scale (Russell et al.. 1980) which asks people to indicate how often they experience such feelings.

Two distinct forms of loneliness exists, emotional isolation and social isolation (Peplau & Perlman, 1982). In **emotional isolation**, person feels a lack of deep emotional attachment to one specific person whereas people who experience **social isolation** suffer from a lack of friends, associates, or relatives (Dugan & Kivett, 1994)

The two types of loneliness often do not go hand in hand. For example, an individual may have many friends and acquaintances and a large extended family, yet lacks any single person with whom to share a deep relationship. Similarly, people who frequently attend parties or eat in crowded cafeterias with many others may still experience a sense of loneliness if they feel emotionally detached from the people who surround them. Although they might not feel socially isolated in such cases, they may experience emotional isolation (Russell et al; 1984; Bell, 1993)

Mostly everyone experiences loneliness, recovery from it often depends on how we interpret and react to its perceived causes (Anderson et al; 1994). In an examination of the duration of loneliness experienced by first-year college students, Caorlyn Cutrona (1982) found that it lasted longer among those who initially blamed themselves for their social isolation. That is, the chronically lonely persons make significantly more internal, stable attributions for their loneliness (for example, "I' m too shy" or "I don't know how to start a new relationship") than those who overcome their sense of isolation. This sort of self-blaming can discourage people from seeking out others and can perpetuate their dissatisfaction with social relationships. On the

other hand, Cutrona found that those who thought of loneliness as being caused by a combination of personal and external factors (for example, "I'm lonely because I don't know anyone here. Things will get better as I meet others") seemed to be more hopeful that they could make things change for the better. True to what would be expected from attribution theory, these external, unstable attributions resulted in relatively short-lived loneliness for most of these students.

Loneliness may be regarded as a 'geriatric giant', leading to impaired quality of life, greater need for institutional care and increased mortality. For the past 30 years, a growing number of studies have focused on loneliness. However the majority of these have been descriptive and cross-sectional. Further longitudinal studies are needed to understand the casual relationship between life-events and loneliness, its prognostic significance and, in particular, whether negative consequences may be alleviated.

Loneliness is a common feeling among older people. Prevalence has been investigated in numbers epidemiological studies, with the proportion of lonely individuals ranging from a few percent to 40 percent.

According to a Euro barometer study conducted few years ago and involving 604 adults, from across Europe, the proportion 'often feeling lonely' varied widely between countries. The proportion was highest in Greece (36%) and in Portugal (23%) and lowest in Denmark and Sweden (4-6%). The proportion varied from 7 to 9 percent in Germany, the Netherlands and the UK, and from 10 to 17% in Belgium, France, Ireland, Luxemburg, Spain and Italy. (Walker A. 1993; Anderson L, 1998).

In a Dutch survey ($n = 3823$, age, range 54 -89 years), 4% reported feeling 'very lonely' and 28% 'moderately lonely' (Van Tilburg TG, De Jong Gierveld J. 1999). In a swedish study, a third (35%) of the older people ($n = 1725$, age > 75 years) feet lonely 'at least sometimes' (Holmen K, Ericsson K, Anderson L. Wimblaad B. 1992; Holmen K, 1994). Another Nordic study found that 36% of older Finns ($n = 1037$, age 60 and over) experienced loneliness 'often or sometimes' (Vaarama M, Hakkarainen A, Laaksonen S. 1998). An American study of survey of very old rural adults ($n = 119$, mean age 83 years), reported that 21% felt lonely 'quite often', whereas 43% felt this way 'sometimes' (Dugan E, Kivett VR 1994).

Several explanations have been proposed for the great variations in reported prevalence. Firstly, some people may be reluctant to identify themselves as lonely because of the stigmatization of loneliness. Secondly, the form of questions, their wording and their context may guide the respondents' answers (Anderson L. 1998). Rokach and Brock (1997) suggested that it is easier to speak about loneliness experienced in the past than about existing loneliness. Jylha and Jokela (1990) proposed that feelings of loneliness are most prevalent in communities that are most integrated, and weakest in communities in which individuality is emphasized. Their assumption was based on the barometer study in which older people's feelings of loneliness were more common in the rural areas of Greece than in Finland, even though in Greece, the respondents seldom live alone, contrary to the situation in Finland.

In order to understand what loneliness in elderly people actually means, it is necessary to distinguish between objective and subjective loneliness. The former refers to the absence of company, either temporary or permanent; in other words it involves those people who are alone. This type includes those people who do not live with anybody, and they account for 14% of the total of elderly people who live in their homes. Among the elderly the tendency to live alone is a function of the person's gender, marital status and the size of the town or city they live in. Women live alone (20%) more frequently than men (7%); elderly people who are separated or divorced (55%) form the largest group of people living alone.

Objective loneliness does not always mean an unpleasant experience: it may become a sought after and enriching experience. Most elderly people living alone, however, have been compelled to do so. Fifty-nine percent of them declare that they have been led to do so, though they have learned to adapt; 36% prefer to live alone; 55% would like to live with their children or their families. Loneliness is more highly valued when it is temporary. Elderly people can find the moments they need to attend to their personal affairs, knowing that after a few moments of "withdrawal" they can count on other people's company.

Subjective loneliness, on other hand, is undergone by those people who feel lonely. It consists of a feeling and one which is feared by 22% of the elderly. Consequently, it is never an intended situation __ as objective loneliness might be __

but is always enforced by the individual's personal situation. The feeling of loneliness increases with age. 27% of the people in the 65-69 age group declare that they feel alone, and the percentage rises to 36% for people in the over 80 age group. As with objective loneliness, gender and marital status have an effect on the feeling of loneliness. This can be seen in the statements made with respect to feeling a certain degree of loneliness: More women (39%) than men (21%) feel lonely. People who have separated (68%) as well as unmarried and widowed people (39%) have a higher tendency to feel lonely than married people (17%).

Even though we have distinguished objective loneliness from subjective loneliness, the two are related. Out of the people who live alone, 38% feel miserable because of loneliness, while among those who live in the company of others the figure reaches only 8%.

Loneliness is not the same as being alone. Many people have times when they are alone through circumstances or choice. Being alone can be experienced as positive, pleasurable, and emotionally refreshing if it is under the individual's control. Solitude is the state of being alone and secluded from other people, and often implies having made conscious choice to be alone. Loneliness is therefore unwilling solitude.

COMMON SYMPTOMS OF LONELINESS

(a) Believing that 'everyone else' has friends

(b) Feeling socially inadequate and socially unskilled

(c) Being convinced that there is something wrong with you

(d) Feeling that no one understands one's situation

(e) Feeling reluctant to attempt to change, or try new things

(f) Feeling 'empty', depressed, or even contemplating suicide

(g) Feeling anxious and/or desperate

Apart from above other different symptoms associated with loneliness. These are discussed below:

(1) **Painful:** Loneliness is painful. Without a doubt, this was the most frequently mentioned experience of loneliness. Words that have been used to describe this type of pain include, hurt, sorrow, ache, sadness, depression, torn up, bleeding, and broken. Clearly the pain is one in which the lonely individual

feels damaged, as though someone their spirit was crushed. It hurts to feel lonely and it hurts even more because we don't have anyone to share it with.

(2) **Feeling lost, having no sense of direction:** Lonely individuals report feeling of being lost, confused and not knowing where they are going, it's because there is no one out there to give support to point out their mistakes, to maintain their sense of identity, and to praise them for doing good job. So, lonely individuals encircled in their own delusions and thinking accordingly with out considering others.

(3) **A feeling of nothingness:** Another frequent feeling is that of nothingness. It has also been described as a void, a black hole, an abyss, hollow, and empty space. Basically there is a feeling that something is missing. When we break up with someone we didn't want to break up with, or we are missing someone we love dearly; we feel a hole in our heart. When we are hungry for food, our stomach growls, we get an empty feeling in the pits of our stomachs, we can't stop thinking about food, and sometimes it even hurts. In the same way, loneliness is a hunger for others, a psychological need that must be satisfied. Aristotle called us social animals, in that we need other people. When people are isolated, abandoned on a deserted island for example, they make pseudo friends in the case of Robinson Crusoe he made friends of the animals there, and in the case of Castaway, he made a friend out of a football. The need for people is a very real need, and therefore when it is not satisfied, the feelings of hunger, of nothingness, of void is bound to occur as well.

(4) **A persistent feeling:** For someone individuals, loneliness has been an affliction that has been going on for a very long time – one of the poets described it as going on for years. These individuals experienced trait loneliness. There are several reasons that someone would experience loneliness over such an extended period of time. The first reason is that the person is in an inescapable situation that is by its very natural isolating circumstances. For example, a person whose job requires constant moving from place to place, will probably not find the time to make secure friendships and may experience loneliness. A second reason is that a person grew up in a rejecting and/or abuse environment.

(5) **Loneliness can be overwhelming:** In some cases, loneliness can be overwhelming, so overwhelming infact that lonely individuals feel like they are about to burst! There is a feeling of despair, not knowing how much more of this painful loneliness one can take, feeling as if one is going to break apart at any minute. It's like blowing up a balloon past its normal capacity. Lonely individuals may feel this way because very often one is experiencing a wide variety of emotions and experiences, and yet there is no one to talk to, no one to share it with.

(6) **Having no control over loneliness:** Some parts describe being unable to take control over their loneliness. Sometimes loneliness is objectified into a person, and loneliness takes on a personality all of its own. In this way it has its own whims and fancies, it behaves in whatever way it feels like. Other poets describe it as a jail, a prison cell, an inescapable reality, anywhere they turn there is loneliness staring them in the face. In these ways loneliness has grown greater than the individual. Individuals who feel this way are probably not facing something important in their lives, they are avoiding dealing with something. Several authors have suggested that this type of loneliness has its roots in childhood; with feelings of unfulfilled love and attachment, experiences so deep inside the person now, that the demon that manifests itself as loneliness seems to have a life and personality all of its own.

(7) **Feeling no emotions, feeling numb:** Cold, frozen, void of true emotions. These are some of descriptions that have been associated with feelings of loneliness as well. It is almost as if we have shutdown our emotions center. As already discussed the fact that loneliness can be very painful, overwhelming, resulting from rejection or abuse. At some point in time, we may decide not to feel anymore, we may become so overburdened with all the pain, the hurt, the sorrow, the loss of control that we shut our emotion center down. We don't want to feel anymore. In these instances, lonely individuals put themselves in cold, frozen places where they don't have to feel anything.

(8) **Feeling other emotions:** Several other emotions like feelings of being scared and afraid, or angry or hatred. For some people who have known what it is like to have close friends and family around, being isolated and alone can be very

frightening and scary. There is a desire for comfort and security. Children, for example, sometimes use their parents as a supportive base, and when strangers or danger approaches they run back to their parents for security. In much the same way this continues throughout a person's life. When that security is gone, and loneliness appears, it can also be a frightening time as well. For other people through, there is a lot of bitterness and resentment. Usually it is against the people whom lonely individuals perceive have hurt them in the past or present. It could be a ex-relationship, or people in general or the world, has hurt them and they are angry. And so, in addition their feelings of loneliness they also respond with feelings of anger.

TYPES OF LONELINESS

There are basically two types of loneliness as given below:

(1) State loneliness

(2) Trait loneliness

State loneliness is temporary and depends on the situation that the person is involved in. For example, a person might go to a new place and not be very familiar with it or a person might take up new job. In such a situation, an individual might initially feel lonely, but build good relationships later.

This loneliness is generated more by the environment than the person. So they probably will experience loneliness only when it's a long rainy day and they have nothing to do, or go on vacation and missing their friends at home or something like it. The loneliness is generated circumstances they are in, and usually doesn't last very long (a day, a week).

Trait loneliness is more stable and enduring. Person experiences loneliness all the time, as an in escapable part of their existence. The inherent traits of the person become a cause for his/her loneliness, which needless to say is miserable condition. The situation does not make any difference to a person with trait loneliness. He/she will feel lonely in a familiar as well as an unfamiliar situation.

This is type of loneliness that follows them everywhere. The loneliness is generated from the person, although particular circumstances might aggravate his

experiences of loneliness... So regardless of the situation or circumstance, when they think about it, they are still lonely.

CONSEQUENCES OF LONELINESS

The Prognostic significance of social isolation is well known: Social isolation predicts **mortality** (Sugisawa H, Liang J, Liu X. 1994;Berkman LF, Syme SL. 1979; Jylha M, Aros. 1989; Olsen RB, Olsen J, Gunnar-Svensson F, Waldstrom B. 1991), **impairment of physical functioning** (Bisschop MI, Kriegsman DM, Van Tillburg TG et al. 2003) and **dementia** (Walker EA, Katon WJ, Russo J et al. 2000). Although the concepts of social isolation and loneliness are close, it has been suggested that the subjective feelings of loneliness have also an independent impact on prognosis. Loneliness has also predicted **impaired survival** (Tilvis RS, Pitkala KH, Jolkkonen J, Strandberg TE. 2000; Penninx BWJH, Van Tilburg T, Krigsman DMW et al. 1997; Herlitz J, Wiklund I, Caidahl K et al. 1998), an **increased use of health services** (Ellaway A, Wood S, Macintyre S. 1999; Geller J, Janson P, McGovern E, Valdini A.1999, an **increased risk of nursing home admission** (Tilvis RS, Pitkala KH, Jolkkonen J, Strandberg TE. 2000; Russell DW, Cutrona CE, de la Mora A, Wallace RB. 1997). This seems to lead to an increased risk of dementia (Tilvis RS, Pitkala KH, Jolkkonen J, Strandberg TE. 2000), and to the poorer outcomes of medical treatment (Walker Ea, Katon WJ, Russo J et al. 2000). Several studies have demonstrated a correlation between increased loneliness and a variety of predictor variables, e.g:- low vision (Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1994; Barron CR, Foxall MJ, Dollen KV, Shull KA, Jones PA.1992; Barron CR, Foxall MJ, Dollen KV, Shull KA, Jones PA. 1994), **reduced hearing** (Chen H-L. 1994; Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B.1992), **low income** (Paplau LA, Perlman D.1992), **low education** (Paplau LA, Perlman D. 1992) and **loss of a spouse** (Thorsen K. 1990; Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1992; Tornstam L. 1988; Jones AA, Victor CR, Vetter NJ. 1985). A Connection has also been demonstrated between a low activity of daily life (ADL) score and loneliness (Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B.1992). However, the picture is not entirely unequivocal, since a survey from Bergen arrived at the opposite conclusion: there was increased loneliness with higher ADL independence (Bondevik M. 1997). A correlation has also been established between the cognitive functional level measured by Mini Mental State

Examination (MMSE) and loneliness (Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1992; Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1993).

An extensive study in Stockholm of 1725 individuals over 80 years old concluded that loneliness is related to age, sex, marital status, social contacts, friends, health and cognitive function. The main predictors for loneliness were dissatisfaction with social contacts and habitation, followed by low self-perceived health and impaired cognitive function (Holmen K, Andersson L, Ericsson K, Rydberg L, Winblad B. 1992). The correlation between self-percieved health and loneliness was also shown in the Albertine project (Lindgren AM, Svardsudd K, Tibblin G. 1994).

Loneliness may lead to serious health-related consequences. In the Gothenburg study Svanborg (1977) showed that loneliness results in more medical consultations (Svanborg A. 1977). Loneliness is one of the three main factors leading to depression (Green BH, Copeland JR, Dewey ME, Sharnra V, Saunders PA, Davidson IA, Sullivan C, McWilliam C. 1992)., and an important cause of suicide and suicide attempts.

DETERMINANTS OF LONELINESS

Contrary to popular stereotypes, it is not the elderly who suffers the most from loneliness. Numerous studies have identified the young adolescents and young adults – as the loneliest age groups (Peplau et al., 1982). As people mature and move beyond the young adult years, their loneliness tends to decrease until relatively late in life, when factors such as poor health and death of loved ones increase social isolation (Green et al., 2000). One reason why adolescents and young adults may be lonelier than older individuals is that young people face many more social transitions, such as falling in and out of love for the first time, leaving family and friends, and training and searching for a full time job – all of which can cause loneliness (Oswald & Clark, 2003). Another reason for this decrease in loneliness with age is that as we mature, we often settle into long-term romantic relationships and marriages, where the accompanying emotional bonds contribute to overall mental health (Rusell, 1982).

There are clear age differences in loneliness, but gender differences are not as clear cut. Some studies have found a slight tendency for women to report greater loneliness than men, yet other studies fail to find any differences at all (Archibald et

al., 1995; Brage et al., 1993). Despite any firm evidence for gender differences in the degree of loneliness, there does appear to be evidence that men and women feel lonely for different reasons. Men tend to feel lonely when deprived of group interaction; women are more likely to feel lonely to when they lack of one-to-one emotional sharing (Stokes & Levin, 1986).

TECHNIQUES TO OVERCOME LONELINESS

Unless a major effort is made to improve interpersonal interactions, loneliness will not magically go away. Lonely individuals tend to retreat into wish-fulfilling fantasies, become absorbed in their occupations, or turn to alcohol and drugs (Revenson, 1981). Some rely on music as a substitute for interpersonal relationships, but songs of separation, heartache and sadness actually agravate feelings of loneliness (Davis & Kraus, 1989). Because these coping strategies only make things worse so two successful techniques, often used together, cognitive therapy and social skill training.

The cognitions of lonely and nonlonely people are found to differ. The self-schema of lonely individual brings about selective attention to negative information involving himself or herself, thus confirming and strengthening an already negative self-concept (Frankel & Frentice-Dunn, 1990). Cognitive therapy is designed to alter such cognitions, especially with respect to social situations. If, for example, a man perceives himself as dull and boring, a therapist may be able to convince him that this self perception is incorrect or to help him give up his false belief that only witty and exciting people can make friends. If a woman reacts to social situations as stressful because she feels others are always evaluating her (Asendorpf, 1989), she can learn that she really isn't the center of everyone else's attention.

Such changes in cognitions need to be accompanied by behavioural changes. Those who are lonely not only lack appropriate social skills, they also are anxious about not possessing these skills (Solano & Koester, 1989). One form of social skills training is to expose a lonely individual to interpersonally successful role models on videotape. The person can also practice social skills in a non-threatening situation and view the results on tape. Specific interactions (such as initiating a conversation) can be prescribed and rehearsed. Sometimes the needed skills are very specific – how to

speak easily on the telephone, give compliments, or improve one's physical appearance.

The effects of these efforts can be remarkable, even in a short period of time (Young, 1982). Once a lonely person thinks about social situations in a new way, learns how best to interact with others, and changes his or her interpersonal style, the resulting interpersonal successes can eliminate loneliness.

Therapy is a common and affective way of treating loneliness, and is often successful. Short term therapy, the most common form for lonely or depressed patients, typically occurs over a period of 10 to 20 weeks. During therapy, emphasis is put on understanding the cause of the problem, reversing the negative thoughts, feelings, and attitudes resulting from the problem, and exploring ways to cure the patient. Some doctors also recommend group therapy as a means to connect with other sufferers and establish a support system.

Doctors also frequently prescribe anti-depressants to patients as a standalone treatment or in conjunction with therapy. It usually takes a few tries before a patient finds the correct anti-depressant medication. Some patients may also develop a resistance to a certain type of medication and need to switch periodically.

Alternative approaches to treating depression are suggested by many doctors. These treatments may include exercise, dieting, hynosis, electro-shock therapy, acupuncture, herbs and many others. Many patients find that participating in these activities fully or partially alleviate symptoms related to depression.

Another treatment for both loneliness and depression is pet therapy, animal assisted therapy, as it is more formally known. Some studies and surveys, as well as anecdotal evidence, provided by volunteer and community organizations, indicate that the presence of animal companions dogs, cats, and even rabbits or guinea pigs can ease feelings of depression and loneliness among some sufferers. According to the centers for Disease Control, there are a number of health benefits associated with pet ownership. In addition to easing feelings of loneliness (because of the increased opportunities for socializing with other pet owners, in addition to the companionship the animal provides), having a pet is associated with lowered blood pressure and decreased levels of cholesterol and triglycerides.

STEPS FOR OVERCOMING LONELINESS

Apart from the techniques discussed above the following steps will also help the people break free from thinking, emotions and behaviours that may be at the root of their loneliness.

Admit the Problem: Only after people acknowledge that they are lonely can take the steps necessary to escape from their isolation.

Accept What Cannot be Changed: The death of a spouse, a relocation away from old friends, and other unalterable circumstances must be faced squarely. God can use transitions in our lives to open doors to new experiences, but we must be willing to let go of the past and move on.

Alter What Can Be Changed: Many of the causes of loneliness can be overcome by practicing :

(a) Work on developing self-esteem by stopping destructive self-talk, such as telling yourself that you are unlikable. There are many good books on the subjects or rational thinking and misbelief therapy that can help.

(b) Practice looking from God's perspective. Study the scriptures and mediate on verses that depict God's view of His believers.

(c) Make it a point to get out of the house at least once a week. Participate in community functions, take a class, etc.

(d) Get involved in a cause. There are many groups looking for faithful volunteers who want to make a difference. Of course, working for a ministry or charity is also a great way to meet people.

Develop New Habits that Build Up Inner Self: As person become a stronger, more self-assured he will find it easier to make new friends and encounter new situations. Try some of these strategies for self-improvement.

(a) Mediate on God's word for relaxation and to ease the effects of stress on their life.

(b) Establish a schedule for a day, weakened or a week. Loneliness often seems more intense when we have nothing to do. Organize their time and be sure to include some outside activities.

(c) Start exercise regularly. Take walks around their neighbourhood, a local park or a shopping mall. They'll feel better physically and emotionally.

Make the most out of your time alone. Aloneness (as opposed to loneliness) can be a very positive experience. Aloneness, or solitude, gives us a chance to reflect on our lives, to mediate on God's will for us and to find healing for the wounds inflicted by the world. Many experts feel that we spend too little time alone and that we would all be better off by planning regular times of solitude in our lives.

Make an Effort to Make New Friends: Often all that is required to escape loneliness is the determination to seek out a new friend. Overcoming shyness and the fear of rejection are usually the biggest obstacles to initiating a friendship. Keep the following in mind when try to establish new relationships:

(a) Look for someone with whom they can share a common interest.

(b) Take the initiative and give the person a call chances are that person may be looking for a friend as well.

(c) Build a friendship slowly. Don't overwhelm a new acquaintance with problems and opinions. With time the openness to express feeling will develop. Give compliments and be thoughtful. Refrain from giving unsolicited advice. Be a good listener.

Consider Buying a Pet: Pets can be a wonderful source of companionship. Don't overlook the possibilities. Pets offer uncomplicated companionship and unquestioning affection. They can even become the catalyst for friendships with other pet owners.

Another consideration that motivated the present author to undertake this proposed research is the existence of some evidence showing relationship between leisure time activities and general health of people.

Leisure time activity is one which we perform when we have free time i.e. leisure time activity is performed apart from those activities which are mandatory. Evening and morning walk, watching T.V. or playing with grand children are the examples of leisure time activities. Elderly individuals who retire from their active services have no mandatory activities to perform. They may either remain idle or may engage themselves in leisure time activities. It has been shown that idle person or the person who have no activities to perform, develops obesity which in turn may have

adverse effect on their general health. Elderly people, on the other hand, who keep them engaged in leisure time activities, are likely to prevent obesity and the occurrence of negative thoughts. Hence, such individuals are likely to experience less stress and hence are likely to have better general health as compared to those elderly individuals who do not perform any leisure time activity. One of the objective of the present study is to test this assumption.

Leisure or free time, is a period of time spent out of work and essential domestic activity. It is also the period of recreational and discretionary time before or after compulsory activities such as eating and sleeping, going to work or running a business, attending school and doing homework, household chores, and day-to-day stress. The distinction between leisure and compulsory activities is loosely applied, i.e. people sometimes do work oriented tasks for pleasure as well as for long term utility.

For an experience to qualify as leisure, it must meet three criteria: (1) The experience is a state of mind. (2) It must be entered into voluntarily. (3) It must be intrinsically motivating of its own merit (Neulinger, 1981).

TYPES OF LEISURE ACTIVITIES

Active Leisure Activities: Active leisure activities involve the exertion of physical or mental energy. Low impact physical activities include walking and yoga, which expand little energy and have little contact or competition. High impact activities such as kick-boxing and soccer consume much energy and are competitive. Some active leisure activities involve almost no physical activity, but do require a substantial mental effort, such as playing chess or painting a picture. Active leisure and recreation overlap significantly.

Passive Leisure Activities: Passive leisure activities are those in which a person does not exert any significant physical or mental energy, such as going to cinema, watching television, or gambling on slot machines. Some leisure experts discourage these types of leisure activity, on the ground that they do not provide the benefits offered by active leisure activities. For example, acting in a community drama (an active leisure activity) could build a person's skills or self-confidence. Nevertheless, passive leisure activities are a good way of relaxing for many people.

Apart from above some other type of leisure activities are:

(a) Hobbies: Among the most popular hobbies are photography, acting, music (playing and listening), gardening, knitting, drawing, collecting stamps, autographs and so forth, hiking, camping, fishing and bird watching.

(b) Reading: Although fewer individuals read now than in the past, plenty of people still love to curl up with a good book. Books allow readers to escape from daily cares, solve mysteries, travel to real or imaginary places, learn useful information, and find inspiration. Mysteries, romances, science fiction, historical novels, biographies, graphic novels, self-help books, magazine – the variety of available reading material is truly astounding.

(c) Surfing the Internet: A relatively new entry into the world of leisure, the Internet offers an amazing array of activities: e-mailing friends and relatives, meeting new people, visit chat rooms on topics of interest, playing multiuser games, listening to music, visiting world-class museums, and taking tours through ancient historic sites are just a few options.

(d) Travel: Many choose their destinations spontaneously, but others are more systematic in their travel plans. For example, some individuals want to travel to all the U.S. national parks or all the major civil war battlefields. Those who can afford it may travel to other countries – to get a taste of real French cooking or a first hand look at what remains of ancient Egyptian civilization.

(e) Games and Puzzles: Some individuals enjoy playing bridge for relaxation; others like to play board games such as Scrabble or chess. Computerized and video games are highly popular, especially with children and adolescents. For some, the day isn't complete without the daily crossword puzzle. Others like to assemble jigsaw puzzles.

(f) Sports: Many people like to play team sports such as bowling or softball, enjoying the benefits of both physical exercise and social interaction. Other enjoy individual sports such as jogging, swimming, surfing, ice skating, or skiing. Kayaking is a popular option that can be done solo or with another.

(g) Volunteer Activities: Helping others appeal to individuals in almost all age groups. Moreover, a person can use his skills to help others in an incredibly diverse array of settings: homeless shelters, hospitals, schools, battered women's shelters,

boy's and girls clubs, and sports teams. These are the best examples of volunteer activities.

EXAMPLES OF LEISURE ACTIVITIES

People who work indoors and spend most of their time sitting and doing sedentary office work can add physical activity to their lives by doing sports during their leisure time, such as playing a ball game, going camping, hiking or fishing. On the other hand, people whose job involves a lot of physical activity may prefer to spend their free time doing quiet, relaxing activities, such as reading books or magazines or watching T.V. some people find that collecting stamps, post cards, badges, model cars or ships, bottles, or antiques is a relaxing hobby.

Free time is organized in many schools and institutions. Schools offer many extracurricular activities including hobby groups, sport activities, and choirs. Other institutions such as retirement homes and hospitals also offer activities such as clubs and meetings for playing games.

Most people like socializing with friends for dinner or a drink after a hard day at work. For many young people, having a regular night out a week is a normal part of their free time, whether it is joining friends for a drink in a pub, dinning out in a restaurant, watching a film, playing video games or dancing the night away at a club.

Some people do leisure activities that have a long term goal. In some cases, people do a leisure activity that they hope to turn into a full time activity (e.g. volunteer paramedics who hope to eventually become professional paramedics). Many people also study part time in evening university or college courses, both for the love of learning, and to help their career prospects.

LEISURE AND RECREATION AS RELATED TO HEALTH

Both leisure and recreation are crucial components of a balanced and healthy life style. Leisure time is a time when people can do what they want, separate from work and other commitments.

Recreation and leisure play an important role in social well-being by providing people with a sense of identity and personal people with a sense of identity and personal autonomy. Involvement in leisure time activities gives greater meaning to individual and community life and contributes to people's overall quality of life.

Recreation can encourage personal growth, self-expression and increased learning opportunities, satisfying needs not met in people's non-leisure time.

For many people, participation in leisure and recreation improves physical and mental health. Recreation often involves a physical activity or sport. Increased physical activity can lead to fewer health problems and higher productivity at work, especially when combined with a balanced diet and healthy life style.

The benefits for mental health are equally important. Several studies have demonstrated links between regular physical activity and a reduction in the symptoms of mild or moderate depression, stress and anxiety. Passive leisure also has benefits for mental health by providing an outlet for the mind. It may provide physical rest, tension release and the daily routine opportunities to enjoy nature and participation in leisure and recreation activities can also have social benefits. It creates opportunities for socialization and contributes to social cohesion by allowing people to connect and network with others. It can also contribute to family bonding as families do things together in their leisure time.

Indicators

Three indicators are here and they are: satisfaction with leisure time, participation in sport and active leisure and participation in cultural and arts activities. Together, these indicators present a picture of how people feel about their leisure and also what they do in their leisure time. The first indicator is satisfaction with leisure time. This measures how people feel about both the quantity and quality of leisure time available to them. The second indicator measures people's participation in sport and active leisure. Moderate physical activity can improve a number of health outcomes, risk factors and disease.

The final indicator, participation in cultural and arts activities, measures people's involvement in cultural activities. Cultural activities contribute to individual growth, as well as provide opportunities for social cohesions and the passing on of cultural traditions.

Sex Differences

There are minimal differences between the sexes in reported satisfaction with leisure time. Eight percent of men and 79 per cent of women report they are "satisfied" or "very satisfied" with their leisure time.

Age Differences

While the majority of people are satisfied with their leisure time, those age 25-49 years are less satisfied overall (74 per cent). This age group tends to have larger work and family commitments than other groups, which may impinge on the time they have available for leisure. In comparison, those aged 15-24 years, and those aged 50-64 years are more likely to report being satisfied with their leisure time with total satisfaction levels of 78 per cent and 83 per cent respectively. Those aged 65 years and over report the highest levels of overall satisfaction with their leisure time (92 per cent).

As mentioned earlier present endeavor is aimed at studying the influence of loneliness and leisure time activities on General Health among elderly people. The main objectives of the study were (1) to investigate the impact of loneliness on general health, (2) to investigate the impact of leisure time activities on general health, (3) to find out whether or not interactional effect exist between two independent variables on dependent variable i.e., general health.

To be more specific, the study was designed to answer the following questions.

1. Do subjects with experiencing high lonely and low lonely differ with respect to general health?
2. Do subjects high and low in leisure time activities differ with respect to general health?
3. Is there an interactional effect of loneliness and leisure time activities on general health?

A 2 x 2 factorial design in which one personality variable (loneliness) and one social variable (leisure time activities), each varying in two ways, was used in the present study. The two values of personality variable, i.e., loneliness were (a) high lonely and (b) low lonely. The two values of social variable, i.e., leisure time activities were (a) greater number of leisure activities and (b) less number of leisure activities. Thus, there were 4 groups of subjects, namely:

1. High Lonely –High in Leisure Time Activities
2. High Lonely – Low in Leisure Time Activities

3. Low Lonely – High in Leisure Time Activities

4. Low Lonely – Low in Leisure Time Activities

In order to form above mentioned four groups of subjects, Loneliness scale (Russell, Paplau & Cutrona, 1980) and Leisure Time Activities check list (Van Willigen & Chadha, 1989) was administered on 410 subjects. The subjects whose score on Loneliness scale fell on or below 1st quartile (Q_1) were considered as Low Lonely while the subjects whose score on Loneliness scale fell on or above 3rd quartile (Q_3) were considered as High lonely. We got two groups of subjects, i.e., High Lonely & Low lonely groups. The subjects whose score on Leisure Time Activities fell on or below 1st quartile (Q_1) were considered as low in leisure time activities, while the subjects whose score on Leisure time activities fell on or above 3rd quartile (Q_3) were considered as high in leisure time activities. Hence four groups of subjects were formed and on these groups the General Health Questionnaire-28 (GHQ-28), developed by Goldberg & Williams (1988), was administered to asses the general health of the subject.

In the present research the following tools were used for data collection.

1. University of California Los Angeles Loneliness Scale (UCLA)

2. Leisure Time Activities

3. General Health Questionnaire-28 (GHQ-28

General Health Questionnaire (GHQ-28) developed by Goldberg & Williams (1998) consists of 28 items assessing psychological symptoms. There are four subscales: (1) Anxiety and Insomnia, (2) Somatization, (3) Social Dysfunction and (4) Severe Depression, with each subscale consisting of 7 items. Each item is rated on a 4-point scale, according to how they have better experienced each GHQ item. The GHQ has demonstrated good internal consistency, high test-retest reliability and also is correlated with depression and as rated by psychiatrists with a clinical sample (Goldberg & Hillier, 1979)

There are two possible ways of scoring the GHQ:

1. A multiple-response scale or "Likert scale", where weights are assigned to each position, e.g. the response options are scored 0, 1, 2 and 3, from "less so than usual"

to "much more than usual". A total score is then produced by adding together each of the scores. A higher score would indicate poorer psychological health.

2. A bimodal response scale known as "GHQ" scoring, which is a simple method of scoring and eliminates errors due to "end-users" and "middle-users". In this method, columns 1 and 2 are both scores 0, and 3 and 4 are both scored 1. Again, scores are summed, a higher score indicating poorer psychological health.

The scoring is done by using first possible way.

The General Health Questionnaire-28 (GHQ) developed by Goldberg & Williams (1988) was administered on all the four groups of subjects. As soon as the subjects finished their task, the test was collected from them and scoring was done. The data thus, obtained were tabulated group-wise and were statistically analyzed using analysis of variance to draw necessary inferences.

F-ratios were calculated for the variation of each independent variable and also for any possible interaction between two variables.

F-ratio for loneliness variation is 85.53 which is significant indicating that high and low lonely groups differ with respect to general health.

F-ratio for leisure time activities is 66.99 which is also significant. The results shows that high in leisure time activities and low in leisure time activities subjects differ with respect to general health.

F-ratio for interaction between loneliness and leisure time activities is 0.85. The result suggests that there is no interactional effect between loneliness and leisure time activities on general health among elderly people.

The main findings of the study are:

(1) Lonely subjects have poorer general health than non-lonely subjects.

(2) Subjects who participate in leisure time activities show better general health than those subjects who do not participate in leisure time activities.

(3) There is no interactional effect of loneliness and leisure time activities on general health.

The first finding of the present research, i.e., lonely subjects show significantly poorer general health as compare to non-lonely subjects, is consistent

with the findings obtained by numerous researchers who have also demonstrated that lonely subjects develop feelings of depression, anxiety, unhappiness, dissatisfaction associated with pessimism, self blame and Shyness (Anderson et al., 1994; Jackson, Soderlind and Weiss, 2000; Jones, Carpenter and Quintana, 1985; Cristensen and Kashy, 1998; Jones et al., 1983). Needless to say any person who develop the above mentioned symptoms cannot be categorized as having good general health. Moreover, other studies have shown a correlation between increased loneliness and a variety of physical deficits such as low vision (Holmen, Andersson, Ericsson, Rydberg and Winblad, 1994; Baron, Foxall, Dollen, Shull and Jones, 1992, 1994), reduced hearing (Cohen, 1994, Holmen, Andersson, Ericsson, Rydberg and Winblad, 1992) and deficit in cognitive functioning as measured by Minimenntal State Examination (Holmen, Andersson, Ericsson, Rydberg and Winblad, 1992, 1993). Similarly Svanborg (1977) showed that loneliness results in more medical examinations and Green et al. (1992) found that loneliness is one of the three main factors leading to depression and societ. Karen Kaasa (1998) observed that there is more loneliness among respondents who report having poor health. All these findings are in agreement with first finding of our investigation.

It is an open secret that healthy individuals find pleasure in leisure time activities, go for a walk, read, go to pubs and coffee shop and attend club for retired people. Such individuals are not only healthy but also are not lonely, hence they find pleasure in performing these activities. Lonley persons, on the other hand, have no pleasure in performing these activities resulting into poor health. In short feeling of loneliness leads to disinterest in leisure time activities, in walking, reading and in attending clubs which inturn leads to poor health. Such a feeling of loneliness was considered so crucial that IMSERSO (Institute for Older Person and Social Services) in collaboration of UNECE (United Nations Economic Commission for Europe) and UNFPA (United Nations Population Fund) undertook two complementary studies (2000) to takle this issue. The first finding of our research to highlighted the seriousness of loneliness and its impact on general health.

Another potential explanation of our finding is that individuals, who experience loneliness, are constantly under severe stress. This continuous state of stress may contribute in the development of minor illness like cold and fever as well as fatal illness like cardiovascular disease and cancer (Kiecolt-Glaser and Glaser, 1992; Frese,

1985) by interfering with efficient operation of immune system. Researches have demonstrated that stressors including disruptions in interpersonal relationships, loneliness, academic pressure, daily hassles and lack of social support impairs immune system resulting into various ailments (Cohen et al., 1992; Miller et al., 1999). Our finding provides empirical evidence to these contentions by demonstrating that lonely people have poorer health as compare to non-lonely persons.

Still another possible explanation of our first finding is that loneliness is a great source of anxiety. Lonely persons always remain anxious and worried. Anxiety and worries are potent determiners of poor health (Anderson et al, 1994; Jackson, Soderlind and Weiss, 2000). Thus loneliness brings out anxiety which inturn deteriorates the health of the individual. The finding under discussion provide empirical support to this notion.

Moreover, the mind of the lonely person is a room for devils. A lonely person always remains busy in negative and self destructing thinking. It is one of the reason why lonely persons develop societal tendencies. Such a life style is bound to have adverse effect on general health of the individuals. The first finding of our research has demonstrated this fact.

In their stimulating article Routasalo and Pitkala (2003) have cited several studies showing positive correlation between loneliness and impairment of physical functioning (Sugisawa, Liang and Liu, 1994; Berkman and Syme, 1979; Jylha and Aro, 1989; Olsen, Olsen, Gunnar Svensson and Waldstrom, 1991) and positive correlation between loneliness and use of health services (Ellaway, Wood, Macintyre, 1999; Geller, Janson, McGovern and Valdini, 1999). Moreover, Routasalo and Pitkala (2003) observed that loneliness is common among elderly people who suffer from depression, negative feelings, have poor quality of life, increased mortality and have increased need for social and health care services. All these findings are in total agreement with the first finding of our research.

Further support to our finding comes from recent study undertaken by Bhatia, Swami, Thakur and Bhatia (2007) who found that out of 361 aged person of Chandigarh, 311 (i.e., 86.1%) persons reported one or more health-related complaints, with an average of two illness.

The idea that a satisfying balance of work, relationship, and leisure time activities will lead to a more rewarding and healthy life was supported by the second finding of our research, which has found that subjects who remain engaged in leisure time activities have better general health than those subjects who do not perform leisure time activities. This finding of our research is in agreement with the findings obtained by other researchers. For instance, Pearson (1998) found job satisfaction and leisure satisfaction are significant predictors of psychological health. Similarly, Caldwell, Smith and Weissinger (1992) reported that subjects who participate at high levels in a variety of leisure activities show higher rates of perceived physical, mental and social health than those subjects who are less involved. More or less similar findings were obtained by Dupuis and Smale (1995) who found that adult of 55 age and older who regularly participate in a variety of leisure activities exhibit better psychological well-being and less depression.

Though the second finding clearly reveals that subjects who remain engaged in leisure time activities show better general health than those who do not engage in such activities. The pertinent question is how leisure time activities help in maintaining good health. One possible answer to this question is that leisure time activities is one of the most effective strategy to cope with stress (Kleiber, Hutchinson and Williams, 2002; Kimball and Freysinger, 2003; Klitzing, 2003; Bowleg et al., 2003; Shields, 2003). It has been established beyond doubt that reduction or elimination of stress improve general health of the individual. Another possible answer is that leisure time activities (physical or non-physical) are undeniably a core component in active living and has been linked to many beneficial outcomes. Such as improved health (Tudor and Bassett, 2004; Brach, Simonsick, Kritchevsky, Yaffe and Newman, 2004; Janisse, Nedd, and Nies, 2004; Brown et al., 2004; Gregg et al., 2003).

One of the most potential explanation of the second finding of our research lies in the fact that activities are important for aging. Participation in leisure time activities by older adults have been found beneficial in improving quality of life and health (Katz, 2000). Menec (2003) and Lennartsson and Silverstein (2001) found that active engagement in social and productive activity predict outcomes like greater happiness, better functioning and reduced mortality whereas solitary activity such as handwork and hobbies predict happiness but had no effect on mortality. The second finding of the present research is also in consonance with these findings since it asserts that

participation in leisure time activities improves general health. Similar findings were recently obtained by Gautam, Saito and Kai (2007) who found that activities in late life have positive effects on the mental health of the older adults. They further observed that saying prayers, watching television, listening to the radio, and participating in physical exercise correlated to lower levels of depression.

Another possible explanation of the second finding is that participating in leisure time activities gives greater meaning one's life contributes in the enhancement of quality of life, helps in personal growth, self expression, increased learning opportunities, satisfies needs not met in one's non-leisure time. All these outcomes of leisure time activities are predictors of good health. Hence, second finding of our research demonstrated that those older adults who participate in leisure time activities show better general health than those who do not participate in leisure time activities. Most recently, Mozaffarian, Furberg, Psaty and Siscovick (2009) strengthened our finding by demonstrating that light to moderate leisure time activities including gardening, outside chores, Golfing, dancing, walking are linked with a significantly lower risk of developing Atrial Fibrillation (AF).

Still another possible explanation of second finding of our study is that lack of leisure time activities inculcate feelings of worthlessness, boredom, meaninglessness in life, essence of loneliness and hopelessness. Moreover, cognitive functioning is adversely affected by lack of leisure time activities. Consequently the health deteriorate, for all these symptoms are strong predictors of poor health.

The last finding of the present research i.e., no interaction exist between loneliness and leisure time activities on general health, indicates that general health scores are independent of loneliness and leisure time activities.

The overall findings of the present research not only open new dimensions in the area of health psychology but also highlight the predictors of good health. More specifically, the findings of the present research establish beyond doubt that loneliness and lack of leisure time activities specially in old age is serious threat to general health. It is, therefore, strongly recommended that old people should not be left alone and they should be encouraged to participate in leisure time activities – they should be provided all possible facilities for such activities which they can perform during free time. By implementing this recommendation, older people would be able to maintain

sound health and live longer. Thus family members are advised that they should not leave their old parents or grandfather and grand mother alone and provide best possible opportunities for making them indulge in leisure time activities. Unfortunately busy life and opting for nuclear family make the lives of older people extremely pathetic and miserable. No one has time to look after them consequently they become helpless lot and need their end in a highly tragic way. The findings of the present research should serve as eye opener for such families, for young members of the family would also become old one day like their fathers or grandfathers and they may be paid in the same coin.

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Appendices

Appendix – I

General Health Questionnaire-28

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

A1	been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2	been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3	Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4	felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5	been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6	Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7	been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1	lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2	had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4	been getting edgy and bad-tempered ?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5	been getting scared or panicky for no good reason ?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6	found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7	been feeling nervous and strung up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

C1	been managing to keep yourself busy and occupied ?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2	been taking longer over the things you do ?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3	felt on the whole you were doing things well ?	Better than usual	About the same	Less well than usual	Much less well
C4	been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6	felt capable of making decisions about things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C7	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less useful than usual	Much less useful
D1	been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3	felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4	thought of the possibility that you might make away with yourself?	Definitely not	I don't thinkso	Has crossed my mind	Definitely have
D5	found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6	found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7	found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A	B	C	D	Total

Appendix – II

Leisure Time Activities Schedule

Instructions :

Given below is a list of activities. You have to report whether you do any of the following during your leisure time. Just tick mark against any activity, which applies to you. More than one response is possible so tick against all the activities that apply to you.

1. Attend movies or watch video.
2. Visit places of worship.
3. Morning and evening walks.
4. Read religious books.
5. Read other books, magazines, and newspapers.
6. Play cards.
7. Listen to radio or watch T.V.
8. Look after children or grand children.
9. Write letters.
10. Household chores, odd jobs.
11. Gardening.
12. Exercise and play games to keep fit.
13. Visit friends, relatives.
14. Speak on the phone.
15. Gossip with family friends.
16. Visit the local mess or club.
17. Listen to music.
18. Nap or rest during the day.
19. Outings with family members.
20. Entertain friends.
21. Attendance at community events.
22. Perform voluntary acts, helps others.
23. Engage in Some Activity.
24. Any other (specify).

Appendix – III

The Revised UCLA Loneliness Scale

Instructions :

Indicate how often you feel the way described in each of the following statements. Circle one number for each.

S. No.	Statements	Never	Rarely	Sometimes	Often
1.	I feel in tune with the people around me.	1	2	3	4
2.	I lack companionship.	1	2	3	4
3.	There is no one I can turn to	1	2	3	4
4.	I do not feel alone	1	2	3	4
5.	I feel part of a group of friends.	1	2	3	4
6.	I have a lot in common with the people around me.	1	2	3	4
7.	I am no longer close to anyone	1	2	3	4
8.	My interest and ideas are not shared by those around me.	1	2	3	4
9.	I am an outgoing person	1	2	3	4
10.	There are people I feel close to	1	2	3	4
11.	I feel left out	1	2	3	4
12.	My social relationships are superficial	1	2	3	4
13.	No one really knows me well	1	2	3	4
14.	I feel isolated from others	1	2	3	4
15.	I can find companionship when I want it.	1	2	3	4
16.	There are people who really understand me.	1	2	3	4
17.	I am unhappy being so withdrawal	1	2	3	4
18.	People are around me but not with me	1	2	3	4
19.	There are people I can talk to	1	2	3	4
20.	There are people I can turn to	1	2	3	4

Name .....

Age ..... Sex .....

Address .....